<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Date</th>
<th>Illness or Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
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<td>1)</td>
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<td>2)</td>
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<tr>
<td>5)</td>
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<td></td>
</tr>
</tbody>
</table>

Medications: (Give doses of all RX and OTC medications, vitamins & dietary supplements.) (May Use Back)

| 1)        | 6)          | 11)          |
| 2)        | 7)          | 12)          |
| 3)        | 8)          | 13)          |
| 4)        | 9)          | 14)          |
| 5)        | 10)         | 15)          |

Allergies to Medicines: (Please specify reaction) Yes No

| 1)        | 4)          |
| 2)        | 5)          |
| 3)        | 6)          |

Food Allergies: (Please specify reaction) Yes No

Latex Allergy: Yes No

Social History: (Circle) Single Married Divorced

Occupation

Smoking (now) Yes No (Past) Yes No How much? __________ How many years? __________

(Circle) Cigarettes cigars pipe chewing tobacco recreational drugs

Alcohol Yes No What kind? __________ How much per day? _________ per week? __________

Family History: Diseases that run in your family (please circle)

Diabetes Heart Disease Cancer High Blood Pressure Allergies Kidney Disease Hemophilia

Bleeding Disorders Thyroid Disease Hearing Loss Reactions to Anesthesia

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>Condition</th>
<th>Alive/Deceased</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Do you have any of the following symptoms or problems? (Please Circle)

<table>
<thead>
<tr>
<th>General:</th>
<th>Fever</th>
<th>Chills</th>
<th>Aches/Pains</th>
<th>Memory Loss</th>
<th>Nausea</th>
<th>Vomiting</th>
<th>Headaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin:</td>
<td>Growths on face, neck or scalp?</td>
<td>Yes</td>
<td>No</td>
<td>Any change in size?</td>
<td>Yes</td>
<td>No</td>
<td>Bleeding?</td>
</tr>
<tr>
<td>Eyes:</td>
<td>Double Vision</td>
<td>Wear Glasses</td>
<td>Loss of Vision</td>
<td>Cataracts</td>
<td>Eye Pain</td>
<td>Itchy Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears:</td>
<td>Buzzing or Ringing</td>
<td>Itching</td>
<td>Pain</td>
<td>Pressure</td>
<td>Popping</td>
<td>Drainage</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Do you wear hearing aids?</td>
<td>R</td>
<td>L</td>
<td>Ear infections in last 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise Exposure</td>
<td>Yes</td>
<td>No</td>
<td>Gun or Firearms use?</td>
<td>Yes</td>
<td>No</td>
<td>Do you wear ear protection?</td>
<td>Yes</td>
</tr>
<tr>
<td>Nose:</td>
<td>Nasal Discharge (color: yellow</td>
<td>green</td>
<td>clear)</td>
<td>Sinus Headaches</td>
<td>Facial Pain</td>
<td>Nosebleeds</td>
<td></td>
</tr>
<tr>
<td>Mouth:</td>
<td>Oral lesions</td>
<td>Ulcers</td>
<td>Bleeding gums</td>
<td>Dental cavities</td>
<td>Chipped or loose teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat:</td>
<td>Sore throat</td>
<td>Pain on swallowing</td>
<td>Enlarged Tonsils</td>
<td>Tonsil Infections</td>
<td>Difficulty Swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs:</td>
<td>Asthma</td>
<td>Emphysema</td>
<td>Pneumonia</td>
<td>Bronchitis</td>
<td>Coughing</td>
<td>SLEEP APNEA</td>
<td></td>
</tr>
<tr>
<td>Heart:</td>
<td>High Blood Pressure</td>
<td>Chest Pain</td>
<td>Murmur</td>
<td>Valve Disease</td>
<td>Heart Attack</td>
<td>Cardiac Surgery/Stints</td>
<td></td>
</tr>
<tr>
<td>GI:</td>
<td>Heart Burn</td>
<td>Hiatal Hernia</td>
<td>Diarrhea</td>
<td>Blood in Stool</td>
<td>Ulcers</td>
<td>Hepatitis</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>GU:</td>
<td>Urinary Tract Infections</td>
<td>Burning</td>
<td>Blood in Urine</td>
<td>Kidney Stones</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood:</td>
<td>Easy Bruising</td>
<td>Bleeding Disorders</td>
<td>Sick Cell Trait/Disease</td>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal:</td>
<td>Broken bones</td>
<td>Arthritis</td>
<td>Loss of Muscle Strength</td>
<td>Painful Joints</td>
<td>Painful Joints</td>
<td>Painful Joints</td>
<td></td>
</tr>
<tr>
<td>Neurological:</td>
<td>Head Injury</td>
<td>Concussion</td>
<td>Stroke</td>
<td>Mini-stroke</td>
<td>Migraines</td>
<td>Headaches</td>
<td>Seizures</td>
</tr>
<tr>
<td>Psychological:</td>
<td>Depression</td>
<td>Anxiety</td>
<td>Mood Disorders</td>
<td>Other Psychological Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine:</td>
<td>Diabetes</td>
<td>Weight Gain/Loss</td>
<td>Hot/Cold Intolerance</td>
<td>Sweating</td>
<td>Nervousness</td>
<td>Nervousness</td>
<td></td>
</tr>
<tr>
<td>Other (comments and additions)</td>
<td>Thyroid/Parathyroid Disease</td>
<td>Goiter/Thyroid Mass</td>
<td>Thyroid Surgery</td>
<td>Iodine Treatment</td>
<td>Radiation Exposure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Signature: ____________________________ Date: __________/_______/__________

Notes: __________________________________________

(for Office Use Only)
Patient Name: _______________________________________________ DOB: ________________

Phone: (Cell) ______________________ (work) ______________________ (home) ______________________

SS#: ______________________ Address: ______________________ (Street City Zip)

Patient’s e-mail Address: ______________________________________________________________________________________

Patient’s Employer Name: _____________________________________________________________________________________

Primary Physician: __________________________________  Referring Physician: __________________________

Responsible Party Name: __________________________________________  Relationship: _________________________________

Insurance Information

Insurance Carrier: ______________________________________________  Insurance ID# _________________________________

Address of Insurance Carrier: __________________________________________________________________________________

(Street City Zip)

Phone # of Insurance Carrier: __________________________________________________________________________________

Subscriber Name (If different than the patient): ____________________________________________________________________

Relationship to Patient: __________________________________________  DOB: ______________________________

Contact Information

Name: __________________________________________________________

Contact Phone Home: ___________________________________    Contact Cell Phone __________________________________

Contact Phone Work: ___________________________________    Relationship: _________________________________________

Is this visit accident related: Yes ____ No ____  Date of accident: ______________________________________________________

Type of Accident:   Motor Vehicle _____  Work _____ School _____ Liability _____

Signatures

• I certify that the completed health and insurance information is true and accurate.
• I have read the fee policy of Tri-County Ear, Nose and Throat PC (TRIENT). I agree to be ultimately responsible for the balance on the account for services rendered. I consent to the diagnostic testing deemed necessary and authorize payment of medical benefits to TRIENT of supplier of services rendered.
• I acknowledge that I have been provided a copy of, or been offered the opportunity to receive from TRIENT notice of Privacy Practices (HIPAA).
• I authorize the release of my medical information to physicians, insurance companies and medical supplier and persons listed below other than immediate family members.
• I give permission for Tri County ENT to contact me via Text Message or Email.

_________________________________________________________     ____________________________

other person    other person     other person

_________________________________________________________     Date:  ____________________________

Patient or Patient Representative’s (Print Name)

_________________________________________________________     Date:  ____________________________

Patient or Patient Representative’s signature for all for the above

_________________________________________________________     Date:  ____________________________

Witness Signature
SINUS QUESTIONNAIRE

Patient’s Name: ______________________________________         Date:_____________

Please check and initial then skip this page if you do not have sinus problems.

Please circle, check or complete the most applicable answer:

1. How long have you had complaints of the nose/sinus?
   ___Days ___Weeks ___Months ___Years ___Never ___Occasionally ___Always ___

2. Do you have difficulty breathing through your nose? ___Never   ____Occasionally ____Always

3. Is it worse on one side rather than the other? ____Yes    ____No

4. Do you have shortness of breath? ____Yes    ____No

5. Do you often have post nasal drainage? ____Yes   ____No
   If yes: ____ Clear   ____Colored (white, green, yellow Eustachian tube dysfunction).

6. Do you have facial pain and/or pressure? ____Yes   ____No
   If yes: please circle applicable area:
   Eyes    Behind eyes    Around eyes   Bridge of nose   Forehead   Temple (side)   Vertex (top of head)

7. How often do you have facial pain and/or pressure?
   ____ all the time   ___3 times/week   ___ once/month   ___ less ___only when there is an infection
   If there have been sinus infections, how frequent? ____ per year.

8. What is the intensity of your pain on a scale of 0-10?__________

9. Have you been placed on antibiotics in the last 12 months? ____Yes ____No
   If yes, how many times ____

10. Do you have loss of smell or taste? (if yes, please circle which sense has been affected)
    ____Yes    ____No

11. Are there environmental factors affecting your sinuses? ____Yes    ____No

12. Is there a seasonal variation? ___Spring___Summer ___ Fall ___ Winter
13. Have you had allergy testing in the past? ___ Yes ___ No
   If yes, what were your allergies?
   ___________________________________________________________________
   ___________________________________________________________________

14. Do weather changes affect your sinuses? ___Yes ___No

15. Have you used or are you using over the counter nose sprays? ___ Yes ___ No
   If yes: ___ Afrin ___ Nasalcrom ___ Dristan ___ Other

16. Have you used or are you using over the count cold or allergy medication? ___ Yes ___ No
   If yes: Name: ________________________ Frequency:____________

17. Have you been placed on prescription nasal sprays? ___Yes ___ No
   If yes which brand:___________________________________________________

18. Have you had previous surgery of the nose or sinus? ___ Yes ___ No

19. Have you had trauma to the nose or face? ___ Yes ___ No

20. Do you have sleep disturbances? ___ Yes ___ No

21. Do you wake up feeling as if you are not getting enough sleep? ___ Yes ___ No
   If yes, how often _________________________________________________

22. Do you have daytime sleepiness? ___ Yes ___ No
   If yes, how often ___________________________________________________
THROAT QUESTIONNAIRE

Patient's Name: ______________________________________ Date: ____________________________

Please initial then skip this page if you do not have throat problems.

Please circle, check or complete the most applicable answer:

Do you have hoarseness?      Yes No
If yes, how long? __________________________

Do you have difficulty swallowing?     Yes No
If yes, how long? __________________________

Do you have a sensation of foreign body in the throat?   Yes No
If yes, how long? __________________________

Do you have pain when swallowing?     Yes No
If yes, how long? __________________________

Do you have constant phlegm and mucous?    Yes No
If yes, how long? __________________________

Do you have “sinus trouble”?      Yes No

Do you have “allergies”?      Yes No

Do you have problems with heartburn/acid indigestion/ fluid or food regurgitating to your throat?     Yes No

Do you have a problem with coughing?     Yes No
If yes, is this productive of mucous? __________________

What type of mucous? White ________ clear colored _______

Is your coughing worse at night?         Yes No
When lying down?       Yes No

Do you have shortness of breath?        Yes No

Do you have wheezing?       Yes No

Do you have any lung problems?     Yes No
If yes, please specify __________________________

____________________________________________________

____________________________________________________
Patient’s Name: ____________________________________________________         Date: ____________________________

Please initial then skip this page if you do not have hearing loss or dizziness.

Please circle, check or complete the most applicable answer:

1. Do you think you have hearing loss?        Yes No
   if yes, is it worse with one ear rather than the other?   Right   Left   Both

2. Do you have to ask people to repeat questions?       Yes No
   How often?   ____all the time _____most of the time ______some of the time

3. Is there ringing or buzzing in the ear?        Yes No
   If yes, is one ear worse than the other?   Right   Left   Both

4. Is there fullness or pressure in the ears?        Yes No

5. Is there ear Pain?        Yes No

6. Do you have drainage or discharge from the ear?        Yes No

7. Have you been treated for ear infections in the past?        Yes No
   If yes, how many?   1 - 2 year ____   4 - 5 year ____   Other____________

8. Is there a relative with significant hearing loss before age 45?      Yes No

9. Do you have a history of previous head or facial trauma?      Yes No

10. Do you have a history of previous ear surgery?       Yes No

11. Have you had exposure to medication which caused hearing loss?     Yes No

12. Do you have a history of exposure to loud noise?       Yes No
   (i.e., blast, loud industrial machinery or gun shot)

13. Do you have any dizziness?         Yes No
   If yes, when did you first notice it? _____________________________________

14. Do you have any sensation of yourself or the environment moving?     Yes No
   How frequently do you have these symptoms?
   Times per day_____   Times per week_____   Other_____________________
   How long do these episodes last? ______/secs   ______/mins ______/hrs

15. Do you have balance disturbance?         Yes No
   If yes, are the symptoms getting __________ worse or __________ the same or __________ better with time?
TRI-COUNTY EAR, NOSE AND THROAT, P.C.

FINANCIAL AND INSURANCE POLICIES

We are committed to providing you with the best possible care. If you have medical insurance. To achieve these goals, we need your assistance and understanding of our payment policies.

**Payment for office visits are due at the time of service.** If you are a member of a managed care insurance plan for which Tri County Ear, nose & throat is a participating provider, a co-payment on the office visit may be accepted. We accept cash, checks and credit cards (mastercard and visa). We will submit claims to your insurance carrier if you provide us with complete information and a signed claim form, if required. We do participate with numerous insurance carriers such as medicare, blue shield of northeastern pennsylvania and its subsidiaries, 65 special, the empire plan (ny government employees), first priority health, aetna us healthcare, geisinger, oxford plan, wellcare and pa medicaid (a referral from the primary care physician is mandatory). Many managed care plans require a written referral from your primary care physician for a specialist visit. If you are a managed care plan member and do not have a referral, you are responsible for all services provided. *Also, any annual deductible and/or co-insurance payments required by your carrier are the patient's financial responsibility.* In some instances, we may accept assignment of insurance benefits.

We will gladly discuss your proposed treatment (diagnostic or surgical) and answer any questions regarding your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance carrier. We are not a party to this contract.

2. Our fees are based on the american medical association fee schedule and are generally considered to fall within the range of the usual, customary and reasonable (U.C.R.) Charges for our region. However, most insurance companies determine their own U.C.R., which may not always be compatible with ours. Any annual deductible and/or co-insurance payments required by your carrier are the patient’s financial responsibility.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. If balance is still owed, you will be responsible for all collection charges.

We realize that temporary financial problems may affect the timely payment of your account. Balances over 90 days old that are ignored will be filed with a collection agency. If you are having financial difficulties, please contact us immediately to discuss this. Returned checks will be subject to additional charges.

I have read the Tri-county ENT fee policy. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or changes in my insurance coverage. I consent to diagnostic testing the physician deems necessary and authorize payment of medical benefits to the physician or supplier for services rendered.
TRI COUNTY EAR, NOSE & THROAT
650 PARK STREET
HONESDALE, PA 18431

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgment that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information requires for anything other than treatment, payment or health care operations requires you to sign and Authorization. Certain discloses required by law or under emergency circumstances may be made without your Acknowledgment or Authorization. Under any circumstance, we will use or disclose only the minimal amount of information necessary from your medical records to accomplish the intended purpose of the disclosures.

Use and Disclosure without Patient Acknowledgment of this Notice
We will attempt in good faith to obtain your signed Acknowledgment that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist to provide physical therapy under appropriate circumstances, or to a facility or other providers should you require surgery or other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclose Without Acknowledgment or Authorization
There are certain circumstances under which we may use or disclose your medical information
without first obtaining your Acknowledgment or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a course of law to do so.

Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerned mental health contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Additional Uses and Disclosures

We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights

You have certain rights with respect to your medical record information as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

3. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psycho-therapy notes contained in them, or information complied in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and addressed to “Privacy Officer” at our address. We will respond
to your request in a timely fashion.

5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12 month period, however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12 month period.

6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.

7. All requests related to your rights herein must be made in writing and addressed to the “Privacy Officer” at the address noted below.

Our Duties
We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at anytime, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints
You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to use) or to the person designated by the U.S. Department of Health and Human Services or Office for Civil Rights, if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

Contact Person
All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer
Tri County Ear, Nose & Throat
650 Park Street
Honesdale, PA 18431

Effective Date
This Notice is effective April 14, 2003 and applies to all protected health information contained in your medical records maintained by us.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Tri County Ear, Nose & Throat’s Notice of Privacy Practices for protected health information.

Date:___________________ Name of Patient ________________________________  Print Name

____________________________________________
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgment
I made a good faith effort to obtain the patient’s written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply)

___ Showing the patient the Notice of Privacy Practices posted in our office.
___ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
___ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
___ Asking the patient to sign this Acknowledgment form.
___ Other (explain in detail) ________________________________

I was unable to obtain the patient’s written Acknowledgment because (check all that apply)

___ The patient refused to sign this form.
___ The patient would not sign the form because the patient said that he/she did not understand the Notice.
___ Other (explain in detail) ________________________________

Date: _____________________ Name:___________________________________

Notes: This written Acknowledgment must be completed no later than the first date health care services or treatment is provided to the patient after April 14, 2003. This Acknowledgment must be retained in patient’s permanent records.