Crossville Office
49 Cleveland St, Suite 220
Crossville, TN 38555
931-219-9990

Oak Ridge Office
700 S. Illinois Ave, Suite A104
Oak Ridge, TN 37830
865-383-0737

PATIENT INTERVIEW FORM:

Please complete all pages

First Name: Last Name: DOB:

Address: State: Zip Code:

Home Phone# Cell Phone#

Email: **SSN:**

Contact Preference: > > > ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Decline to Specify

Occupation: **Marital Status:**

REASON for Visit: **Height** **Weight**

PHARMACY: ***Location:***

PHYSICIAN's NAME: ☐ Referring ☐ Primary

SEX:	**Preferred LANGUAGE:**	**RACE(s):** ☐ Declines to Specify	**ETHNICITY:**
☐ Male	☐ English ☐ Decline	☐ White ☐ American Indian/Alaskan Native	☐ Hispanic or Latino
☐ Female	☐ Other ____________	☐ Asian ☐ Native Hawaiian/Pacific Islander	☐ NOT Hispanic or Latino
☐ Other	☐ Requesting Translator	☐ Other ☐ Black/African American	☐ Declines to specify

Insured Party / Responsible Party for Minors:

Name (print): DOB: SSN:

Address:

FOR MINORs ONLY: I, ________________________________ (Print Name) hereby state that I am the:

○ Biological Parent ○ Legal Guardian ○ Other (specify) ______________ of the Patient and authorized to sign on their behalf. I understand that if I am not the Biological Parent that I must provide legal documentation.

Rev 2/14/2025

ALLERGIES: ☐ Patient has NO known Drug Allergies ☐ Patient has No known allergies

Allergies as Listed:

Current Medications: (Include Prescription, Over the counter, Supplements/Herbs) ☐ > **NONE**

Name	*Dose*	*Name*	*Dose*

>> **I consent to obtaining a history of my medications purchased at pharmacies >** ☐ **Yes** ☐ **No**

Past or Present Medical Conditions:

(*Check all that apply*) ☐ **NONE**

- O Acid Reflux
- O Allergies
- O Anemia
- O Anxiety
- O Asthma
- O Barrett's Esophagus
- O Blood Clots / DVT
- O Cataracts
- O Cancer Lung
- O Cancer Skin
- O Cancer Throat
- O COPD
- O Depression
- O Diabetes
- O Esophageal Disorders
- O Glaucoma
- O Heart Attack
- O Hemophilia
- O Hepatitis
- O High Blood Pressure
- O High Cholesterol
- O HIV
- O Kidney Failure
- O Migraine
- O Other Bleeding Disorder
- O Other Cancer ________
- O Sinusitis
- O Sleep Apnea
- O Stroke
- O Thyroid Disorder
- O Tuberculosis
- O Other ________________

Previous Procedures / Surgeries:

(List Type, & Month/Year) ☐ **NONE**

Any complications from Anesthesia? ☐ No ☐ Yes

>> **Hospitalizations:** **(Reason > Month/Year)**________________________________

Family Medical History: *(health / illnesses)* ☐ **No Knowledge of Family History**

Mother: ______________________ Father: ______________________

Sister: ______________________ Brother: ______________________

Daughter: ______________________ Son: ______________________

Other Family:

Rev 2/14/2025

Tobacco /Smoking Status:

- ☐ NEVER a Smoker
- ☐ CURRENT Smoker - How many a day? ____________
- ☐ FORMER Smoker - When did you quit? ____________
- ☐ Tobacco User (non-smoker) Type of Use & Frequency:
- ☐ Unknown if ever smoked
- ☐ Current, occasional smoker, not every day
- ☐ Smoker, current status unknown

>> **Vaping:** ☐ NONE **If Yes**, How many times a day? _______ When did you begin Vaping? ________

Alcohol ➡ ☐ **NONE**, I Do Not drink Alcohol

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes, How often on average do you have an alcoholic beverage? ____________________

- ☐ Less < than seven drinks weekly, and no more than three drinks on any one occasion.
- ☐ More > than seven drinks weekly, and/or more than three drinks on any one occasion.
- ☐ Less < than 14 drinks weekly and no more than four drinks on any one occasion.
- ☐ More > than 14 drinks weekly and/or more than four drinks on any one occasion.
- ☐ Former alcohol abuse, now sober.

>> **Caffeine Use:** How many cups on average per day ____________________ ☐ N/A

Review of Symptoms: ***Please check any of the following that you currently have or recently had:***

- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Ringing Ears
- ☐ Painful Eye
- ☐ Itchy Eyes
- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Frequent Productive Cough
- ☐ Frequent non-Productive Cough
- ☐ Belching Sour Material into Throat
- ☐ Nasal Congestion
- ☐ Post Nasal Drainage
- ☐ Sneezing
- ☐ Severe Face Pain
- ☐ Frequent Nosebleeds
- ☐ Dizziness
- ☐ Frequent Headache
- ☐ Blacking Out or Fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Hives
- ☐ Hoarseness or Voice Change
- ☐ Mouth Ulcer
- ☐ Partials or Dentures
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heartbeats
- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ Cold Feeling
- ☐ Change in sense of Smell
- ☐ Change in sense of taste
- ☐ Bruise Easily
- ☐ Bleed excessively after injury
- ☐ Leg Cramps
- ☐ Swelling of Ankles
- ☐ Swelling of Joints
- ☐ Stiffness in Joints
- ☐ Appetite is Increased
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Mass/Lump in Neck
- ☐ Mass/Lump in Armpits
- ☐ Mass/Lump in Groin
- ☐ ____________________

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Consent to the Use and Disclosure of Health Information

NAME: ____ DOB: ___________________________

Our Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice, you may obtain a revised copy by contacting our office. **The patient understands that**:

* Protected Health Information may be disclosed or used for treatment, payment or health Care options.
* The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this notice.
* The Practice reserves the right to change the Notice of Privacy Policies.
* The Patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition treatment upon the execution of this Consent.

I Authorize my medical information to be discussed / disclosed to the family member or friend listed below:

____

Full Name: Relation: Phone Number:

________________________________ ________________________________

Physician Name: Other:

Detailed messages regarding test results and appointment reminders can be left on answering machine or voicemail: No __________ Yes ___________ Please list Phone Number ________________________

By supplying my home and/or mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

I acknowledge that I have been provided with an opportunity to review the Notice of Privacy Practices for Rocky Top ENT & Allergy.

X ____ ____________________

Signature of Patient or Legal Representative Date

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Jonathan Hafner, M.D.

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services. I also herby authorize the release of pertinent medical information to insurance carriers and/or other consulting physicians who may require it.

I understand that I am responsible for giving ***Rocky Top ENT and Allergy*** my correct insurance information, primary and secondary, and understand that I will be held responsible for unpaid charges if I supply the incorrect information.

I agree to be responsible for collection costs (balance due plus 30%) and/or attorney fees incurred in collecting a delinquent account. Interest will not be charged on the outstanding balance.

** This disclosure is in compliance with the Truth-In-Lending Act. **

PRINT: ______________________________ DOB: ______________

Patient Name

______________________________ ______________

Signature of Patient or Legal Representative Date

Rev 2/14/2025