Swallowing Specialist of Central Georgia, LLC

610 Third Street Suite 200
Macon, GA 31201

Phone: 478-344-2328 Fax: 478-216-9186

Demographic Information

PLEASE ANSWER ALL INFORMATION OR PLACE NONE WHERE NEEDED

Name: _____

Prefix First MI Last Suffix

DOB: _____ **Social Security Number:** _____

Male: ___ **Female:** ___ **Marital Status: ( ) Single ( )Married ( )Divorced ( ) Widow (er) ( ) Other**

Address: _____

Street City State Zip Code

Mailing Address if different from above: _____

Phone: (H)_____ **(C)**_____**(W)**_____

Messages can be left on: ( ) Home ( )Cell ( ) Work ( ) Email:_____

Emergency Contact: _____ **Phone:** _____

Race (per census bureau categorization): ( ) American Indian ( ) Asian ( ) African American ( ) Hispanic or Latino ( ) Native Hawaiian or Other Pacific Islander ( ) White ( ) Unknown

How did you find us: ( ) Referred ( ) Friend ( ) Family ( ) Phonebook ( ) Website ( ) Other:_____

Employer/School Name or Retired/Disabled: _____

Spouse's Name: _____ **Phone:** _____

Spouse's DOB: _____ **Spouse's Place of Employment:** _____

Preferred Pharmacy: _____

Name City Phone

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INSURANCE:

Primary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number:** _____

Guarantor's Name: _____ **DOB:** _____

Relationship to Guarantor: _____

Secondary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number:** _____

Guarantor's Name: _____ **DOB:** _____

Relationship to Guarantor: _____

Please note that our office does not file Medicaid claims, you will be responsible for the balance after your primary insurance has paid, we will provide you with an itemized Statement to send to Medicaid for your reimbursement purposes.

By signing below, you give permission to Swallowing Specialist of Central Georgia, LLC to video record and take picture images of procedures performed while under our care as well as permission to send said videos and picture images to your referring and primary doctor as needed.

Patient Name Printed: _____

Signature of Patient: _____ **Date Signed:** _____

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Please list all doctors you are currently seeing. It is important that you give us their First and Last Name, Phone Number and City/State. Thank you for your help!

Primary Doctor: _____

Name City/State Phone

Referring Doctor: _____

Name City/State Phone

Seen For: _____: _____

Name City/State Phone

Seen For: _____: _____

Name City/State Phone

Seen For: _____: _____

Name City/State Phone

Seen For: _____: _____

Name City/State Phone

Seen For: _____: _____

Name City/State Phone

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Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Information Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We also required by Federal law to maintain the confidentiality of your health information. Although these laws are complicated, all medical providers are required to provide you with the following important information:

The HIPPA law permits the use and disclosure of personal-identifiable health information as needed for diagnosis, treatment, or billing of health care services, provided that any such disclosure must be limited to the minimum necessary information to accomplish these purposes, and only to properly qualified persons. Special safeguards must be maintained to minimize any chance of inadvertent disclosures of personally identifiable health information to unauthorized person, particularly of especially sensitive information such as psychological or HIV status. We are committed to maintaining the security and privacy of all information (including billing information) contained in my medical records, including electronic records and data transmissions.

Use and disclosure of your health information in certain circumstances:

The following additional circumstances may also require me to disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect such information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. I will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or Foreign Military Forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In order to advert a serious threat to the health and safety of your or any other person pursuant to applicable law.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in my use of disclosure of your health information treatment, payment, or health care operations. Additionally, you have the right to request that I restrict my disclosure of your health care operations. Additionally, you have the right to request that I restrict my disclosure or your health information to only certain individuals involved in your care of payment for your care, such as family members and friends as provided by 45CFR & 164.522. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes as outlined in 45CFR & 164.524. You must submit your request in writing to the office of Tamatha Rutherford, SLP.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for my practice as provided for in 45CFR & 164.526. To request an amendment, your request must be made in writing and submitted to Tamatha Rutherford, SLP. You must provide a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice, contact the receptionist.
6. Accounting of disclosures. You have the right to receive an accounting of all disclosures made of your health information as provided by 45CFR & 164.526.
7. Right to file a complaint. If you believe your privacy right have been violated, you may file a complaint with my practice or with the secretary of the U.S. Department of Health and Human Services. To file a complaint with our office, contact Tamatha Rutherford, SLP. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. My practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
9. If you have any questions regarding this notice or my health information privacy policies, contact Tamatha Rutherford, SLP.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices

Print Name: _____

Signature: _____ Date Signed: _____

Swallowing Specialists of Central Ga, LLC

Dysphagia Questionnaire

Please complete this form and bring with you on the date of your appointment.

What are your complaints regarding your swallowing? _____

_____

Date of onset of swallowing problems: _____

Check the problems you are currently experiencing: (If a choice is provided, circle the appropriate answer.)

- □ Drooling during non-mealtimes
- □ Losing food or liquid or both from your mouth during meals
- □ Difficulty drinking with a straw
- □ Difficulty chewing
- □ Difficulty moving food or liquid or both out of the mouth and into the throat
- □ Difficulty getting the swallow started
- □ Pain during swallow
- □ Food or liquid or both coming out of the nose
- □ Coughing or choking with food or liquid or both
- □ Frequent throat clearing or coughing or both after the swallow
- □ Sneezing during meals
- □ Eyes watering during meals
- □ Nose running during meals
- □ Sensation of food sticking in the throat or chest- where specifically? _____
- □ Difficulty swallowing pills
- □ Needing to avoid certain food or liquid or both
- □ Regurgitation or being unable to keep food or liquid or both down
- □ Burping during or after or both meals
- □ Coughing or choking on saliva during non-mealtimes
- □ Foreign body sensation in throat
- □ Sudden coughing after lying down
- □ Waking at night coughing or choking
- □ Thickened/excess mucus or secretions
- □ Ulcers or sores in mouth
- □ Dry mouth
- □ Decreased mouth/jaw opening
- □ Other _____

Current Diet: o Nothing by mouth (PEG/N-G tube/TPN) □ Oral intake

Solids: □ Regular □ Soft □ Pureed

Liquids: □ Thin or regular □ Nectar-thick □ Honey-thick

How much of your daily intake do you eat by mouth?

ALL MORE THAN HALF HALF LESS THAN HALF NONE

How much of your daily intake goes into a feeding tube?

ALL MORE THAN HALF HALF LESS THAN HALF NONE

Do you frequently use a straw with liquids? Yes No

Do you avoid certain foods because of your swallowing difficulties? Yes No

Explain: _____

Dysphagia Questionnaire

Does it take you longer to eat a meal than others? Yes No

When do you have difficulty at mealtimes? The beginning/middle/end/throughout the meal. (Circle one.)

How frequently do you have trouble? All the time/Sometimes/Occasionally. (Circle one.)

Have you had previous dysphagia therapy with or without NMES/ e-stim? Yes No
Date:_____ Location:_____

Have you had a previous MBS (Modified Barium Swallow study) performed with a Speech-Language Pathologist in a Radiology suite? Yes No
Date:_____ Results:_____

Have you had a previous FEES assessment (Fiberoptic Endoscopic Evaluation of Swallowing) with a flexible scope inserted into the nose? Yes No
Date:_____ Results:_____

Have you had any recent Chest X-Rays? Yes No
Date:_____ Results:_____

Pertinent Medical History:

□ **Reflux/GERD/LPRD** Current reflux medication and dosage/frequency:_____

□ Esophageal disorders: Explain:_____

□ History of aspiration □ Pneumonia: Date:_____

□ Neurological deficits: Explain:_____

□ Cardiac problems/disorders: Explain:_____

□ Pulmonary/Respiratory disorders: Explain:_____

□ Head and Neck Cancer: Location/type and date of diagnosis:_____

Do you have an active, untreated lesion in your head or neck?_____

Surgery and dates:_____

_____

Chemotherapy/Radiation (Circle one or both) **Current/Completed (Circle one)**

Date of completion:_____or # of treatments to date:_____

□ History of Voice Problems: Explain:_____

Other Medical History:

□ Arthritis
□ Blood Sugar (high/low)
□ High Blood Pressure
□ Joint/Bone Disease
□ Asthma (adult/childhood onset)
□ Diabetes (adult/childhood onset)
□ Kidney/Bladder Disease
□ cancer (other than head and neck)
□ Bronchitis
□ Headaches
□ Liver Disease
□ Tuberculosis

□ Depression
□ Endocrine Disorder
□ Peripheral neuropathy
□ Internal cardiac defibrillator
□ Thyroid disease
□ GI Disorders (hernia, ulcers, colitis, etc.)
□ Deep Brain Stimulation implants
□ Bleeding Problems
□ Sinus Disease
□ Pacemaker

Other:_____

Current Medications including over the counter: _____

_____

Do you have allergies to foods? drugs? environmental?_____

_____

Dentition/Teeth: □ Natural □ Partial/Bridges □ Dentures □ Missing teeth □ Edentulous/No teeth

Current weight: ____ lbs. □ Recent Weight Loss: lbs.

Hydration:
How much of the following do you drink per day? 1 cup/glass = 8 ounces

Physicians:
Primary:_____Phone number:_____

Gastroenterologist:_____Phone number:_____

ENT:_____Phone number:_____

Oncology:_____**Phone** number:_____

Radio-Oncology:_____**Phone** number:_____

Are you currently taking antihistamines?_____ If yes, list type and dosage._____

Are you currently using tobacco products? If yes, list type_____
How much (packs/cans/etc.) per day? For how long?___ _

Have you used tobacco products in the past? If yes, list type._____
How much (packs/cans/etc.) per day? For how long?___ Date of cessation_ _

Are you currently on oxygen at home?_____if so, how many liters?_____

Are you using CPAP at night:_____

Do you take Vitamin C supplements?___ If yes, please list amount (mg) per day_____

Social History:

Marital Status: □ Married □ Single □ Widowed □ Divorced

Occupation:_____

Living arrangements and current level of assistance needed for meal preparations:

□ House □ Apartment
□ Independent Living Facility □ Assisted Living Facility
□ Skilled Nursing Facility

□ Caregiver □ No caregiver

Goals regarding swallowing:_____

_____

_____

_____

I acknowledge, that all information provided is current and accurate to the best of my ability.

Printed Name:_____Date:_____

Signature:_____Date:_____

Reviewed by:_____.Date:_____