NAME ____ AGE ____________TODAY'S DATE______________________

PLEASE COMPLETE AND PRINT CLEARLY

REASON FOR TODAY'S VISIT AND DURATION OF PROBLEM (FOR HOW LONG)

____

____

____

LIST ALL CURRENT MEDICATIONS AND DOSAGES INCLUDING OVER-THE-COUNTER MEDICATIONS:

____

____

____

____

PAST MEDICAL HISTORY/REVIEW OF SYMPTOMS (Circle all that apply to you as the patient)

Breast disease	Angina	Unexplained fever	HIV/AIDS
Cancer: (type____________)	Chest pain	Unexplained weight loss	Anemia
Change in smell	Heart attack	Asthma	Easy bleeding
Change in taste	Heart murmur	Bronchitis/pneumonia	Diabetes
Glaucoma	High blood pressure	Chronic cough	Hemophilia
Headaches	High cholesterol	Tuberculosis	Arthritis
Head injury	High triglycerides	Wheezing	Joint pain
Hearing loss	Palpitations	Colitis	Gout
Migraines	Poor sleep (apnea)	Difficulty urinating	Herpes
Prostate disease	Seizures	Kidney disease	Lyme's disease
Ringing in ears	Stroke	Liver disease	Fatigue
Skin rashes	Stomach ulcers	Cold/heat intolerance	Other: ____________________________

Have you fallen in the past year? Y/N

Are you pregnant: Y/N

Do you have a bleeding disorder? Y/N If yes, explain: ____

Are you taking aspirin, ibuprofen, or blood thinning products? Y/N If yes, explain: ____

PAST SURGICAL HISTORY:

List all operations you have had: ____

____

____

ALLERGIC HISTORY: If allergic to any of these items **(<u>especially antibiotics</u>)** circle and specify

MEDICINES ANTIBIOTICS FOODS SURGICAL TAPE LATEX NONE

SPECIFY CIRCLED ITEMS: ____

WHAT IS THE REACTION?

____

FAMILY HISTORY (Circle conditions in your blood relatives only)

Allergies	Diabetes	High blood pressure	Lung problems
Bleeding problems	Heart problems	Kidney problems	Liver problems
Cancer (type)	Hearing loss	Other ____	

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many packs per day? __________ How many years___________

Do you drink? Yes No If yes, how many drinks per week? _________________

*** **NAME OF PRIMARY CARE PHYSICIAN/CITY**____

*** **HOW DID YOU HEAR ABOUT US? Google -- Insurance Company -- My Doctor -- Friend/Family**

*** **WHO REFERRED YOU TO US?** ____

*** **PHARMACY NAME / ADDRESS:**____

I agree that payment for services rendered are my responsibility, and I authorize the release of any medical information and to appeal if necessary to process my claims. I have received the notice of Privacy Practices.

Signature ____ **Date** ________________________________

<u>(PLEASE CONTINUE ON THE OTHER SIDE)</u>

Ear, Nose & Throat Care, P.C. / Patient Information

PLEASE PRINT

**** (Circle One) Male / Female **** Marital Status: Single Married Divorced Widowed

Patient Name: ____Today's Date: _______________

Social Security Number: ____________________ Date of Birth: ____/____/______ Height______ Weight ______

Address: ____________________________________ City, State, Zip: ____________________________

Home Phone Number: _________________________ Cell Phone Number: __________________________

Email Address: ____

Emergency Contact: _________________________ Phone # ________________ Relation: ______________

Is this due to Workman's Compensation? ___________ Date of Accident: _____________________________

Case Manager: ____Case #__________________________

Employer Name: ____ Phone # _______________________

Address:: ________________________________ City, State, Zip _________________________________

Responsible Party (PLEASE COMPLETE IF PATIENT IS A MINOR)

Name: _______________________________________ Date of Birth: ____________________________

Address: _________________________________ City, State, Zip: ________________________________

Social Security Number: _________________________ Telephone Number: _________________________

Relationship to Patient: ____

Insurance Coverage (Primary)

Name of Insurance: ____

Subscriber Name: ____ Male ______ Female _______

Member ID#: _____________________________________Group ID#____________________________

Relationship to Patient: ____ Date of Birth ______________

Insurance Coverage (Secondary)

Name of Insurance: ____

Subscriber Name: ____ Male _______ Female________

Member ID#: ____________________________________ Group ID# ___________________________

Relationship to Patient: ____Date of Birth _______________