

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
Ringin 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 (especially antibiotics) 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 _____

(PLEASE CONTINUE ON THE OTHER SIDE)

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 _____