NAME _____ AGE _____TODAY'S DATE_____

PLEASE COMPLETE AND PRINT CLEARLY

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

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

❑ **I am currently not on any medication**

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
COVID 19 date:_____	Heart attack	Asthma	Easy bleeding
Change in taste	Heart murmur	Bronchitis/pneumonia	Diabetes
Change in smell	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/trouble sleeping	Difficulty urinating	Herpes
Prostate disease	Sleep Apnea	Kidney disease	Lyme's disease
Ringing in ears	Seizures	Liver disease	Fatigue
Skin rashes	Stroke	Cold/heat intolerance	Other: _____
Glaucoma	Stomach ulcers		

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. If appeal is needed to have claims processed by my insurance, I authorize ENT Care PC to appeal and release any medical information. I have received the Patient Privacy Policy Notice.

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: _____

Employer Name: _____ Phone # _____

Address:_____ City, State, Zip _____

Is this due to Workman's Compensation? _____ Date of Accident: _____
Case Manager: _____Case #_____

Responsible Parties (PLEASE COMPLETE IF PATIENT IS A MINOR)

Name: _____ Date of Birth: _____relation to patient_____

Address: _____ City, State, Zip: _____

Name: _____ Date of Birth: _____relation to patient_____

Address: _____ City, State, Zip: _____

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 _____