Patient Information

Last Name	First Name	Middle Initial
Gender	Date of Birth	
Street Address		
City	State	Zip Code
Home Phone / Cell Phone	Email	
Primary Care Physician	Who referred you to us?	
Employer	Occupation	
Preferred Pharmacy		
Emergency Contact Name	Phone Number	Relationship
Language / Ethnicity	Race	
Primary Insurance Card Holder's Name and DOB		Relationship

Policies

Authorization: I authorize the release of any medical or other information necessary to process this claim and I direct payment of my insurance benefit to ENT Center, LLP. I will provide necessary information such as referrals, insurance forms prior to my visit. If said information is not provided, I understand I will be held responsible for payment in full at the time of visit.

For Medicare patients only: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Summary Of Notice Of Privacy Practices

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the notice). This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. Uses and Disclosures of Your Health Information. We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. Other Uses and Disclosures. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. Your Health Information Rights. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:

a. You may request restrictions on certain uses and disclosures of your information
b. You may request that you receive your information from us in a certain way
c. You may inspect and copy your medical records
d. You may request an amendment to any record you believe is inaccurate
e. You may request an accounting of disclosures made of your records

4. Changes to the Notice. We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.

5. Complaints. You may file a complaint to our Privacy Official or with the federal government as detailed in the Notice. You will not be penalized for filing a complaint.

I have read the above information and understand my responsibilities. I understand the practice has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

Signature of Patient/Guardian: ___________________________________ Date: __________________________

Print Name: ____

Patient Name: **DOB:** **Date:**

Reason for Visit:

Height: **Weight:**

Past Medical History		
Seasonal allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Esophageal Reflux	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No
Other Medical Problems:		

Family History		
Anesthesia Problems	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No

Allergy to Medications	
Medication	**Reaction**

Review of Systems - Have you had any of the following?					
Shortness of Breath	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Watery/itchy eyes	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No	Weight gain	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No	Night sweats	☐ Yes	☐ No
Joint aches	☐ Yes	☐ No	Swollen glands	☐ Yes	☐ No
Rash/hives	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anxiety/panic disorder	☐ Yes	☐ No

Social History

For Adult Patients

Tobacco Use	☐ Never smoker	☐ Former smoker	☐ Current smoker
		Year started? ___________	
		If quit, what year? _______	
		Packs per day: _________	
Alcohol Use?	☐ Yes	☐ No	Drinks per week:
Coffee Use?	☐ Yes	☐ No	Cups per day:

For Pediatric Patients

Student/Daycare	☐ Yes	☐ No
Smoker at home	☐ Yes	☐ No
Siblings	☐ Yes	☐ No

Have you had two or more falls in the past year?	☐ Yes	☐ No
Have you had any falls in the past year resulting in injury?	☐ Yes	☐ No

Please list any hospitalizations and surgeries you have had and the year:

Please list current medications and dosage (include prescription, over-the-counter, and vitamins/supplements):