Patient Account #

ENT ASSOCIATES MEDICAL GROUP

Name			Sex	Home Phone ( )
Address				Work Phone ( )
City	State	Zip		Cell Phone ( )
Date of Birth	Age	Marital Status		Spouse's Name
Social Security Number	Driver's License Number			E-Mail (optional)
Occupation		Employer		
Emergency Contact (Not living with you)	Phone			Relationship to Patient

Insured party (if different than above)

Name			Sex	Home Phone
Address				Work Phone
City	State	Zip		Cell Phone
Social Security Number	Driver's License Number			E-Mail (optional)
Occupation		Employer		

Primary Care MD: ______________________________ Primary Care MD Phone____________________________

Referral Source:_______________________________ Insurance Company:_______________________________

May we leave messages with private health info on your answering machine at home?__ At work?__ Cell voicemail?__

Please list with whom we can discuss your private health information:____

I ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

I have reviewed a copy of the Notice of Privacy Practices of ENT Associates Medical Group. This Notice describes how ENT Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

ENT Associates reserves the right to charge for broken appointments without 24 hours advance notice.

I hereby assign to ENT Associates all benefits provided by my insurance policy, not to exceed the charges for services rendered.

I am financially responsible for healthcare charges not covered by insurance.

Signature (Responsible Party):____________________________________ Date: __________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (please circle yes or no and the condition, if appropriate)

Condition			Condition			Condition		
Migraine Headaches	N	Y	Rheumatic Fever	N	Y	Other Rheumatic Diseases	N	Y
Stroke / TIA	N	Y	High Blood Pressure	N	Y	Cancer (other than skin)	N	Y
Seizures / Epilepsy	N	Y	Blood Clots	N	Y	Skin Cancer	N	Y
Head Injury	N	Y	Acid Reflux / Heartburn	N	Y	Other chronic skin problems	N	Y
Mental Illness	N	Y	Stomach Ulcers	N	Y	Thyroid problems	N	Y
Glaucoma	N	Y	Hiatal Hernia	N	Y	Diabetes	N	Y
EAR Disease, Injury or Surg	N	Y	Liver Problems or Disease	N	Y	High Cholesterol / Lipids	N	Y
Allergies / Eczema	N	Y	Pancreatitis	N	Y	Problems with Anesthesia	N	Y
Asthma	N	Y	Colitis / Spastic Colon	N	Y	Excessive bleeding	N	Y
Pneumonia	N	Y	Other colon problems	N	Y	Excessive bruising	N	Y
Emphysema / COPD	N	Y	Kidney problems	N	Y	Previous blood transfusion	N	Y
Angina / Heart Attack	N	Y	Prostate problems	N	Y	Anemia	N	Y
Mitral Valve Prolapse	N	Y	Spine or Back problems	N	Y	Drug Addiction	N	Y
Antibiotics needed before dentistry?	N	Y	Osteoarthritis	N	Y	Injectable Drug Addiction	N	Y
Heart Arrhythmia	N	Y	Fibromyalgia	N	Y	Exposure or At Risk for HIV	N	Y
Heart Murmur	N	Y	Rheumatoid Arthritis	N	Y	HIV Disease or AIDS	N	Y
Congestive Heart Failure	N	Y	Lupus	N	Y	Sexually Transmitted Disease	N	Y

Please list all **surgical** procedures and approximate years:

____

____

____

Please list any other hospitalizations or major injuries:

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FAMILY HISTORY	**Alive?**	**Age (now or at death)**	**Good Health?**	**Major Illnesses**	**Cause of Death**
Father					
Mother					
Sibling					
Sibling					
Sibling/Children					

OTHER CONDITONS PRESENT IN FAMILY MEMBERS (please circle)

Migraine	Stroke	Hearing Loss	Allergies	Asthma
Heart Disease	Hypertension	Diabetes	Cancer	Arthritis
Thyroid	Bleeding Disorder	Addiction	Alcoholism	Psychiatric

Other family conditions (please list):______________________________

Do you smoke tobacco? ______ Have you ever?_________ If yes, how much?_________ If quit, what year?_____________

Do you drink alcohol?___ How much or how often?_____________ How many caffeinated drinks do you take a day?_____

Have you traveled out of the country in the last six months? ___ Where?______________________________

Do you have any on-the-job chemical, fume or loud noise exposures?___ If yes, what type(s)?________________________

Please circle if you currently suffer from the following:

General
- Weight Loss
- Fever
- Chills
- Night Sweats
- Fatigue
- Poor Quality Sleep
- Poor Appetite
- Change in Appetite
- Excessive Thirst
- Excessive Sweating
- Cold Intolerance
- Heat Intolerance
- Hair Loss / Change in Skin

EENT
- Eye Pain
- Visual Changes
- Double Vision
- Floaters
- Visual Flashes
- Ear Pain
- Ear Drainage
- Hearing Loss
- Ear Ringing
- Dizziness
- Change in Smell
- Nasal Discharge
- Nasal Congestion
- Facial Pain
- Facial Congestion
- Nose Bleeds
- Post Nasal Drip
- Mouth Sores
- Bleeding Gums
- Sore Throat
- Difficulty Swallowing
- Snoring
- Change in Voice
- Neck Lump

Pulmonary
- Positive TB Skin Test
- Persistent Cough
- Shortness of Breath
- Breathless during Exercise
- Breathless when laying flat
- Phlegm in Chest
- Wheezing
- Coughing up Blood

Cardiovascular
- Chest Pain
- Rapid Heartbeat
- Skipped Beats / Palpitations
- Swelling in Legs
- Blood Clots in Legs
- Leg Pain while Walking

GI
- Nausea
- Vomiting
- Indigestion
- Heartburn
- Abdominal Pain
- Constipation
- Diarrhea
- Change in Bowel Habits
- Vomiting Blood
- Blood in Stool
- Hemorrhoids
- Dark Black Stools

GU
- Pain with Urination
- Frequent Urination
- Urination at Night
- Hard to Start Urine Stream
- Blood or Pus in Urine
- Leakage of Urine

Skin
- Easy Bruising
- Easy Bleeding
- Change in Moles
- Non-Healing Sores
- Rash

Men's Health
- Breast Lump
- Penis Discharge
- Sore on Penis
- Lump on Testicle
- Difficulty with Erection
- Last Prostate Exam?_______________

Women's Health
- Breast Lump or change
- Nipple Discharge
- Change in Menstruation
- Pelvic Pain
- Abnormal PAP Smear
- Vaginal Discharge
- Number of Pregnancies:____________
- Number of Births:_________________
- Last Menstrual Period?_____________
- Last PAP?_________________________
- Last Mammogram?________________
- Last Pelvic Exam?__________________

MusculoSkeletal
- Limb Pain
- Joint Pain
- Weakness
- Numbness
- Swelling
- Back Problems
- Leg Cramps at Night

Neuro
- Headaches
- Dizziness
- Fainting
- Seizures
- Changes in the Senses
- Changes in Memory
- Changes in Coordination
- Difficulty with Walking
- Changes in Balance
- Excess Stress
- Feelings of Depression

MEDICINE and ALLERGY LIST

Please list medications to which you are allergic or sensitive (Write “None”, if appropriate):______________________________

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List the medicines that you are **currently** taking. Please remember to list prescription, over-the-counter, and herbal medicines.

If regular doses of pain or anti-inflammatory medicines are used, list these. Also list topical medicines including drops, creams.

Name	Strength	Taken How Often	For How Long