Patient Account #

ENT ASSOCIATES MEDICAL GROUP

Name					Sex	Home Phone ( )
Address						Work Phone ( )
City			State	Zip		Cell Phone ( )
Date of Birth	Age	Marital Status	Preferred Language			Spouse's Name
Social Security Number			Race/Ethnicity (optional)			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:_____

PATIENT NAME:_____

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

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

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

_____

_____

_____

Please list **any other hospitalizations** or major injuries:

_____

_____

_____

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)

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

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)?_____

Patient Name:_____

Please circle if you <u>currently</u> 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

Patient Name:________________________________

MEDICINE and ALLERGY LIST

Please list medications to which you are allergic or sensitive **(Write "None", if appropriate)**:________________________

____

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