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**Otolaryngology-Head and Neck Surgery • Facial Plastic Surgery**

Welcome to our office. Please complete these forms as completely and accurately as possible.

**TODAY'S DATE:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name	First Name	Middle Initial
Parent Name (if Patient is a minor)		
Patient Age	Date of Birth	Sex: Male Female Social Security Number
Marital Status	Single Married Divorced Separated Widowed	
Home Address	City	State Zip
Home Phone	Work Phone	Cellular Phone
E-Mail Address		
Your Occupation	Your Employer	
Spouse Name	Spouse's Employer	
Whom May We Thank for Referring You to Our Practice?		

**NOTIFY IN CASE OF EMERGENCY**

Name	Relationship
Home Phone	Work Phone Cellular Phone
Nearest Relative (not living with you)	
Home Phone	Work Phone Cellular Phone

**WHO IS YOUR DOCTOR? (PRIMARY CARE AND SPECIALIST)**

Physician Name	Specialty	Address

<b>Signature :</b> _____	<b>Date:</b> _____
<b>Signature :</b> _____	<b>Date:</b> _____
<b>Signature :</b> _____	<b>Date:</b> _____
<b>Signature :</b> _____	<b>Date:</b> _____

## PRIMARY INSURANCE

Primary Insurance Name		Telephone Number	
Claim Address	City	State	Zip
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Number
Insurance ID	Group #		

## SECONDARY INSURANCE

Secondary Insurance Name		Telephone Number	
Claim Address	City	State	Zip
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Number
Insurance ID	Group #		

## MY PHARMACY

Pharmacy Name	Location	Phone Number
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## PATIENT RESPONSIBILITY

*Please read our Financial Policy Statement and Agreement and sign below.*

### Medical Records

I authorize the use of this form on all my insurance submissions. I authorize the release of my medical information to all my insurance companies if they so request.

### Payment and Collections

I understand that payment is due at the time of service. I understand that I am personally responsible for any and all costs not covered by my insurance. I understand that if my account is turned over to collection that I will be responsible for 33 1/3% attorney fees, court costs, search costs and 18% annual interest on unpaid balances.

### Insurance Payments

I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor. I understand it is my responsibility to notify and update the office if my insurance or address or phone information changes.

### Insurance Denial of Payment because not "Medically Necessary"

I agree to accept responsibility for payment in full for any charges for services requested by me and rendered that are denied by my insurance because the insurance company deems the service to be not "medically necessary".

### Cancellation Policy and Fees

I understand that 24-hour notice is required to cancel all appointments and that if sufficient notice is not given, then a **no-show fee** will be charged to my account and this will not be covered by my insurance. The no-show fee is **\$50** for office visits and **\$150** for procedures, allergy testing and audiology appointments.

**Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_

<b>MEDICAL HISTORY</b>	
What is the reason for your visit?	
How long have you had the problem?	
How severe is the problem?	
Prior treatments....	

<b>WHAT MEDICAL PROBLEMS DO YOU HAVE?</b>			
<b>NO</b>	<b>YES</b>	<b>PROBLEM</b>	<b>DATE / DETAILS</b>
		Major Illness	
		Major Injury	
		Hospitalization	
		Acid Reflux	
		Anemia	
		Asthma	
		Bleeding / Bruising Problems	
		Blood Clots	
		Cancer	
		Diabetes	
		Heart Problems	
		High Blood Pressure	
		Kidney Problems	
		Liver Problems	
		Lung Problems	
		Thyroid Problems	
		<b>CHILDREN ONLY</b>	
		Born Premature	
		Congenital Defects	
		Reading/Learning Disability	
		<b>WOMEN ONLY</b>	
		Are you pregnant?	

Name: \_\_\_\_\_

**WHAT SURGERIES HAVE YOU HAD?**

NO	YES	PROCEDURE NAME	DATE	SURGEON / LOCATION
		Tonsillectomy		
		Adenoidectomy		
		Ear Surgery		
		Nose Surgery		
		Throat/Neck Surgery		
		Anesthesia Problems		
		<b>OTHER</b> <i>Please list...</i>		

**PLEASE LIST ALL OF YOUR MEDICATIONS**

**NONE** (include over the counter medications)

	NAME / DOSE
Antacids/ Heartburn Meds	
Antibiotics	
Aspirin	
Birth control pills	
Blood pressure pills	
Beta Blockers	
Blood thinner	
Diabetes pills	
Pain pills	
Tranquilizers	
Vitamin E	
Water pills	

**ARE YOU ALLERGIC TO ANY MEDICATIONS?**

**Yes**  **NO**

NAME OF DRUG	REACTION (e.g. Hives, Wheezing, Anaphylaxis...)

Name: \_\_\_\_\_

## SOCIAL HISTORY / HABITS / RISK FACTORS

NO	YES	QUESTION	DETAILS
		<b>Tobacco:</b>	
		Cigarettes	No packs/day:
		Cigars / Pipe / Chewing Tobacco	Quantity:
		Have you ever smoked in the past?	Date started: _____ Date stopped: _____
		<b>Alcohol:</b>	Never Rarely Socially Daily Alcoholic
		Beer / Wine / Liquor	
		<b>Drugs:</b>	
		Cocaine / Marijuana / _____	
		<b>Family:</b>	
		Children	Number: _____ Ages: _____
		Occupation	

## FAMILY HISTORY

NO	YES	PROBLEM	RELATION	YEAR	<i>FOR DOCTOR NOTES</i>
		Allergies			
		Asthma			
		Arthritis			
		Bleeding problems			
		Cancer			
		Diabetes			
		Heart Trouble			
		Mental Illness			
		Migraine headaches			
		Stroke			
		Thyroid Disease / Goiter			
		Tuberculosis			
		Ear Infections			
		Otosclerosis			
		Glaucoma			
		Hearing Loss			
		Other: please list:			

## DO YOU HAVE TROUBLE HEARING?

No	Yes	
		Do you have trouble hearing in noisy environments?
		Does anyone ever complain about your hearing?
		Do you use or own hearing aids?
		Have you ever been told that you would benefit from hearing aids?

Name: \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?**

NO	YES		NO	YES	
		<b>CONSTITUTIONAL</b>			<b>GASTROINTESTINAL</b>
		Weight Loss or Gain			Nausea/Vomiting
		Fatigue			Heartburn
		Fever/ Chills			Bowel Changes
		<b>VOICE AND THROAT</b>			Abdominal Pain
		Change in Voice			<b>CARDIOVASCULAR</b>
		Trouble Swallowing			Chest Pain
		Sore Throat			Leg Swelling
		<b>EARS</b>			<b>URINARY / REPRODUCTIVE</b>
		Hearing Loss			Do you think you could be pregnant now?
		Ringing or ear noise			Difficulty urinating
		Pain in ears			<b>MUSCULOSKELETAL</b>
		Dizziness/Imbalance			Pain in Neck
		<b>MOUTH AND NECK</b>			Stiff Joints
		Lumps in neck			<b>PSYCHIATRIC / EMOTIONAL</b>
		Headaches			Anxiety
		Nosebleeds			Depression
		<b>EYES</b>			<b>NEUROLOGIC</b>
		Blurred Vision			Numbness
		Double Vision			Weakness/Paralysis
		<b>RESPIRATORY</b>			Tingling
		Cough			Difficulty Walking
		Wheezing			<b>Skin</b>
		Shortness of Breath			Itching/ Rash
		Coughing up Blood			Non healing lesion
		<b>ENDOCRINE / METABOLIC</b>			<b>Hematological</b>
		Heat or Cold Intolerance			Bleeding or Bruising
		Hair Change			Enlarged Lymph Nodes

**Reviewed by Patient:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIAN:** I have reviewed the PMH, SH, FH and ROS