Ear, Nose & Throat Consultants
Patient Medical Hx Form

Name: _____
Date: ___/___/_____ DOB: ___/___/_____ Age: _____

Reason for today's visit: _____

Medications (include Aspirin, vitamins and herbal remedies, birth control and over-the-counter allergy and cold meds):
_____
_____

Allergies to Medications: **___None known**
Med _____ rash/hives/swelling/anaphylaxis/breathing problem
Med _____ rash/hives/swelling/anaphylaxis/breathing problem
Med _____ rash/hives/swelling/anaphylaxis/breathing problem

Your Past Medical History:	Yes	No	(please explain if yes)
Autoimmune Disease	O	O	_____
Cancer	O	O	_____
Diabetes	O	O	_____
Digestive/stomach/intestinal disease	O	O	_____
Elevated Cholesterol	O	O	_____
Environmental Allergy	O	O	_____
Glaucoma/eye disorder	O	O	_____
Heart Disease	O	O	_____
Heart Murmur	O	O	_____
High Blood Pressure	O	O	_____
Neurologic/seizure/depression/ADD/Anxiety	O	O	_____
Respiratory/lung disease/Asthma/OSA	O	O	_____
Thyroid disease	O	O	_____
Urologic/kidney disease	O	O	_____
Other Medical Disease	O	O	_____

Surgical History
□ **No prior surgery**
Previous Surgery (include operations and dates): ___ _____
_____
_____

Family Hx Please note which relatives have had the following:

	Yes	No	(please explain if yes)
Cancer	O	O	_____
Hearing Loss	O	O	_____
Allergy	O	O	_____
Diabetes	O	O	_____
Hypertension	O	O	_____
Stroke	O	O	_____
Mental Illness	O	O	_____
Bleeding disorders	O	O	_____
Headaches	O	O	_____
Heart Disease	O	O	_____
Adverse reaction to anesthesia	O	O	(Malignant Hyperthermia?)_____
Other or Unknown	O	O	_____

Social Hx
What is your occupation? _____ Former occupation if retired_____
Caffeine Use _____ If Yes, please list source and frequency_____
How often do you drink alcohol?_____
Exposed to high level of Environmental noise or Occupation Exposure _____
How much do you smoke? _____ packs/day (Enter 0 if no)
If none, did you ever smoke? _____If yes, when did you quit? _____
Chewey tobacco? If yes, frequency_____ Marijuana use?_____

Patient Medical Hx Form, page 2

Patient name _____

Review of Systems

Please indicate whether **you presently** have any of the following symptoms:

	Yes	No
General/Constitutional		
Fatigue	O	O
Weight Loss	O	O
Weight Gain	O	O
Allergy/Immunology		
Itchy Nose	O	O
Previous Allergy Testing	O	O
Hives	O	O
Itching	O	O
Sneezing	O	O
Watery Eyes	O	O
Opthalmologic		
Blurred Vision	O	O
Discharge	O	O
Eye Pain	O	O
Itching and Redness	O	O
Ears, Nose, Mouth, Throat		
Ear Itch	O	O
Ear Drainage	O	O
Post Nasal Drip	O	O
Dizziness	O	O
Loss of Balance	O	O
Sinus Pain	O	O
Sinus Pressure	O	O
Nasal Congestion	O	O
Loss of Smell	O	O
Loss of Taste	O	O
Hoarseness	O	O
Sore Throat	O	O
Throat Clearing	O	O
Blocked Ear	O	O
Decreased Hearing	O	O
Decreased Sense of Smell	O	O
Dry Mouth	O	O
Ear Pain	O	O
Ear Problems	O	O
History of Broken Nose	O	O
Mouth Breathing at Night	O	O
Nosebleeds	O	O
Ringing in Ears	O	O
Snoring	O	O
Endocrine		
Thyroid Nodule	O	O
Cold intolerance	O	O
Thyroid Problems	O	O
Respiratory		
Asthma	O	O
Cough	O	O
Coughing up blood	O	O
Shortness of breath	O	O
Wheezing	O	O
Cardiovascular		
Chest pain	O	O
Heart failure	O	O
High Blood Pressure	O	O
Irregular Heartbeats	O	O
Gastrointestinal		
Belching	O	O
Colitis	O	O
Difficulty Swallowing	O	O
Heart Burn	O	O
Hematology		
Night Sweats	O	O
Clotting Disorder	O	O
Bleeding Problems	O	O
Easy Bruising	O	O
Prolonged Bleeding	O	O
Swollen Glands	O	O
Family member w/bleeding problems	O	O
Women Only		
Pregnancy	O	O
Post-menopausal	O	O
Genitourinary		
Difficulty Urinating	O	O
Musculoskeletal		
Muscle Aches	O	O
Painful Joints	O	O
Skin		
Change in Skin	O	O
Hair Changes	O	O
Rash	O	O
Skin Cancer	O	O
Neurologic		
Difficulty Speaking	O	O
Fainting	O	O
Headaches	O	O
Seizures	O	O
Stroke	O	O
Tingling/Numbness	O	O
Tremor	O	O
Psychiatric		
Anxiety	O	O
Depressed Mood	O	O
Psychiatric Condition	O	O
Substance Abuse	O	O

Height:_____ Weight:_____

Reviewed by: _____M.D. Date_____

EAR NOSE & THROAT CONSULTANTS, INC.
PATIENT INFORMATION AND CONSENT

Patient Name: _____ Date of Birth: _____

Please initial all boxes and sign on the signature line*

Thank you for choosing Ear Nose and Throat Consultants. We take your healthcare very seriously. In order to take care of you in the best way and according to your wishes we need your permission for several different things. Please initial each section to indicate consent. Please inquire with staff if you wish to receive a full copy of the consent.

➡ _____ **I give permission to be treated by the providers and staff at Ear Nose & Throat Consultants, Inc**. Initialing indicates that you give us permission to provide you care. No means we are unable to treat you and you will not be brought into an exam room.

➡ _____ **I give permission to Ear Nose & Throat Consultants, Inc. to check my prescription eligibility and prescription history.**

➡ _____ **I give permission to Ear Nose & Throat Consultants, Inc. to bill my insurance and acknowledge that I have been notified of the billing policy at Ear Nose and Throat Consultants**. This allows us to furnish your information to your insurance company for purposes of payment for services rendered. It also allows us to collect from you and funds not covered by your insurance such as co-pays and deductibles. Please be aware, we are unable to know in advance how your individual policy will handle the charges given the terms of your policy. Some common office based care may be applied a higher co-pay or be applied to your deductible. These portions of your charge will be your responsibility. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

➡ _____**If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician**. If a referral is not obtained, I may be responsible for payment of services. Not initialing here would make you responsible for the full amount of the charges related to the services you receive according to our billing policy.

By signing this form I acknowledge that I am requesting evaluation and treatment from ENT Consultants. If I am a member of a managed care health plan, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained, I may be responsible for payment of services. Referrals, co-payments and deductibles for services rendered are your responsibility. Office procedures may be required to provide you appropriate care. Procedures might include nasal endoscopy, excision of lesions, biopsies, removal of impacted ear wax, and flexible fiberoptic laryngoscopy, or other office procedures deemed necessary by the provider. Some insurance companies bill these procedures under their "surgery" guidelines. You may be responsible for separate co-pay or deductible for "surgical" procedures after insurance payments and adjustments. I have the right to notify the provider prior to a procedure if I choose not to have the procedure: otherwise, my signature on this form represents consent for these commonly done procedures. I will assume liability if a diagnosis is delayed or missed due to my refusal.

This agreement is valid for the duration of your care for any of the providers at Ear Nose & Throat Consultants, Inc. Please feel free to ask questions if you have any concerns regarding this agreement. You are responsible for the timely payment of your account.

Effective Period. This Consent Form will remain in effect until the day you withdraw your authorization, submit a written request revising your consent(s), or until such time as Ear Nose & Throat Consultants, Inc. ceases, whichever is sooner.

PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW:

➡ **Signature of Patient or Patient's Legal Representative: _____ Date: _____**

Print Patient's Name: _____

Print Name of Legal Representative (if applicable): _____

Ear, Nose and Throat Consultants
Patient Registration Form

Name / Address

Last Name: _____ First Name: _____ MI:_____
Date of Birth: _____/_____/_____ Gender: Male /Female/Other_____
If minor: Parent's name:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Home Phone: ( ) _____-_____ Mobile phone: ( ) _____ - _____
Email: _____
Emergency contact /relation:_____ Contact Tel #: ( ) _____-_____

By submitting your telephone number here and any future update telephone numbers, you agree that a representative of ENT Consultants can contact you at these numbers, potentially using automated technology (including text/SMS messaging) or a prerecorded message. Your consent is not an obligation to receive any of our services. This authorization will remain in effect until a written request is submitted.

Preferred method of telephone communication: **Please circle one:** Home / Mobile

➡ _____ _____
Patient / Guardian or representative) Date

**** Optional: Please write N/A if you decline to answer the following information****
Primary Language: _____ Ethnicity_____ Race_____

Referring Physician

****Primary Care Doctor:** _____ **Tel: ( ) _____-_____**
Address: _____

Insurance Information (Guarantor Info)

The * sections are mandatory if you are not the primary subscriber
Primary Insurance: (only complete if insurance card not present)_____
***Name of insured if not self:*_____ *Relation to Insured _____**
***Insured Date of Birth:* _____/_____/_____**
Insured Employer:_____
Secondary Insurance: _____
Name of insured, if not self:_____ **Relation to Insured _____**
Insured Date of Birth: _____/_____/_____

Is this Workers Comp.? Y/N Is this Motor Vehicle? Y/N Is this Personal Injury? Y/N

Signature (Please sign)

➡ **Your Signature/(Guardian signature)** _____ **Date:**_____

Patient Name : _____

DOB: _____

Account # _____ **(Completed by Staff)**

EAR, NOSE AND THROAT CONSULTANTS, INC.

HIPAA (PRIVACY POLICY) ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted disease information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

➡ _____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

_____

Nature of Relationship / Designated Authority if applicable

I also give consent to any representative of Ear, Nose & Throat consultants, Inc. to discuss my medical condition without limitations with the folllowing person(s)_____