Patient's Last Name _______________________________ First Name__________________________________ Middle Initial ____

SSN ________________________ Date of Birth _______________ Age _________ Sex: F M

Address _______________________________ Apt.#_______ City ________________ State ______ Zip _________ County_________

Race: ____ Language: ___________________________________

Name & Address of Primary Care (Family) Physician / Pediatrician ____

Referring Physician Name & Address (if different) ____

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone ____________________________ Day Phone __________________________ Cell Phone ________________________

E-mail Address ____

Employer: ____________________________________ Employer Address: ____

What is or was your occupation? ____ ☐ Retired?

Name of Spouse/Parent/Legal Guardian __________________________________ DOB ___________ SSN ____________________

Primary Medical Insurance

Policy Holder Name ________________________________ Policy Holder SSN ___________________ Policy Holder DOB __________

Plan Name ________________ Policy Holder # ___________________________ Patient's Policy # ___________________________

Group Name (if applicable) ________________________ Group Number (if applicable) _______________

Ins. Co. Address ____ Ins. Co. Phone Number ____________________________

Effective Date _______________ Co-pay Amount ________________ Deductible ___________________

Secondary Medical Insurance

Policy Holder Name ______________________________ Policy Holder SSN ___________________ Policy Holder DOB __________

Plan Name ________________ Policy Holder # __________________________ Patient's Policy # ___________________________

Group Name (if applicable) ________________________ Group Number (if applicable) _______________

Ins. Co. Address ____ Ins. Co. Phone Number ____________________________

Effective Date _______________ Co-pay Amount ________________ Deductible ___________________

Is this visit covered by Workers' Comp? __________________________________ No Fault? _________________________________

Emergency Contact: ______________________________________ Phone #: ___________________________________

Doctor you are here to see ______________________________ I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received ENT & Allergy Associates notice of privacy practice.**

Responsible Party Signature: ____ *Date:* _______________

Patient Name: ______________________________ DOB:__________ Date:__________

What is the reason you are here today? ______________________________

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: ____________

ALLERGIES? ☐ **No Allergies**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or

Allow ENT & Allergy Assoc to obtain medication history via electronic means directly from insurer/pharmacy ______initial here

☐ **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)______________________________

***MEDICAL / SURGICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular:	Yes	Surgery/Management
Coronary Artery Disease	☐	__________
Elevated Cholesterol (hyperlipidemia)	☐	__________
High Blood Pressure (hypertension)	☐	__________
Gastrointestinal:		
Hepatitis	☐	__________
Hernia	☐	__________
Gastroesophageal Reflux	☐	__________
Genitourinary:		
Prostate enlargement (Benign Prostate Hyperplasia)	☐	__________
Kidney Stones (Nephrolithiasis)	☐	__________
Renal Failure (Acute)	☐	__________
Ear / Nose / Throat: (HEENT)		
Cataracts	☐	__________
Glaucoma	☐	__________
Chronic Ear Infections (Otitis Media)	☐	__________
Hearing Loss	☐	__________
Sinus Problems (chronic sinusitis)	☐	__________
Nasal Polyps	☐	__________
Nasal Allergies	☐	__________
Recurrent Tonsillitis	☐	__________
Tinnitus	☐	__________
Vertigo	☐	__________
Hematologic :		
Anemia	☐	__________

Immunologic:	Yes	Surgery/Management
Allergies Type: __________	☐	__________
Food Allergies Type: __________	☐	__________
Infectious Disease:		
Mononucleosis	☐	__________
STD Type: __________	☐	__________
Metabolic/endocrine:		
Diabetes Type: __________	☐	__________
Thyroid deficiency (hypothyroidism)	☐	__________
Thyroid excess (hyperthyroidism)	☐	__________
Neoplastic:		
Cancer Type: __________	☐	__________
Neurologic:		
Migraine	☐	__________
Obstetric:		
Pregnancy Date(s): __________	☐	__________
Psychiatric:		
Adjustment Disorder - Anxiety	☐	__________
Major Depression	☐	__________
Pulmonary:		
Asthma	☐	__________
COPD	☐	__________
Emphysema	☐	__________
Sleep Apnea	☐	__________
Tuberculosis	☐	__________

If YES to any of the above Diagnosis was surgery performed?

What__________ **Where/When**______________________ **By Who**__________

FAMILY HISTORY of: **Who**

Condition	Who	Condition	Who	Condition	Who
ADD/ADHD	☐	CVA (Stroke)	☐	Learning disability	☐
Alcoholism	☐	Depression	☐	Mental illness	☐
Allergies	☐	Developmental delay	☐	Migraines	☐
Alzheimer's Disease	☐	Diabetes	☐	Obesity	☐
Asthma	☐	Eczema	☐	Osteoarthritis	☐
Blood disease	☐	Hearing deficiency	☐	Osteoporosis	☐
CAD (Coronary Artery Disease)	☐	Hyperlipidemia	☐	PVD	☐
CAD-Premature	☐	Hypertension	☐	Renal disease	☐
Cancer Type: _______________	☐	Irritable Bowel Syndrome	☐	Seizure disorder	☐

Other Family History: ____

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**
Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** ________________________________ **Amount per day?** ____________

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems
No Yes
☐ ☐ Fatigue
☐ ☐ Fever
☐ ☐ Night sweats
☐ ☐ Weight loss
☐ ☐ Weight gain

Eye problems
No Yes
☐ ☐ Double vision
☐ ☐ Itchy eyes
☐ ☐ Redness

Ear problems
No Yes
☐ ☐ Drainage
☐ ☐ Hearing loss
☐ ☐ Infections
☐ ☐ Dizziness
☐ ☐ Itchiness
☐ ☐ Exposure to Excessive Noise
☐ ☐ Ear pain
☐ ☐ Ringing /noise in ears

Nose & Sinus problems
No Yes
☐ ☐ Congestion
☐ ☐ Facial Pain
☐ ☐ Mouth Breathing
☐ ☐ Nose Bleeds
☐ ☐ Sneezing
☐ ☐ Runny Nose
☐ ☐ Post Nasal Drainage

Mouth & Throat problems
No Yes
☐ ☐ Difficulty Swallowing
☐ ☐ Sleep Apnea
☐ ☐ Snoring
☐ ☐ Sore Throat
☐ ☐ Hoarseness
☐ ☐ Sores/Ulcers in Mouth

Heart or circulation problems
No Yes
☐ ☐ Heart Murmur
☐ ☐ Chest pain
☐ ☐ Swelling of Ankles/Edema
☐ ☐ Blacking Out
☐ ☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems
No Yes
☐ ☐ Cough
☐ ☐ Shortness of Breath
☐ ☐ Wheezing

Musculoskeletal:
No Yes
☐ ☐ Leg pain

Stomach problems
No Yes
☐ ☐ Abdominal Pain
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Heartburn
☐ ☐ Nausea
☐ ☐ Vomiting

Brain or Nervous system problems
No Yes
☐ ☐ Headache
☐ ☐ Seizures
☐ ☐ Focal Weakness
☐ ☐ Numbness

Glands & Hormone problems
No Yes
☐ ☐ Heat Intolerance
☐ ☐ Cold Intolerance
☐ ☐ Neck Enlargement/Goiter

Blood or Lymph nodes problems
No Yes
☐ ☐ Easy Bleeding
☐ ☐ Easy Bruising

Allergy problems
No Yes
☐ ☐ Food Allergies
☐ ☐ Bee Sting Allergies
☐ ☐ Environmental Allergies
☐ ☐ Urticaria / Hives

Skin
No Yes
☐ ☐ Itchy Skin/ Pruritis
☐ ☐ Rash
☐ ☐ Contact Allergy

Patient Name: ____ **DOB:** ___________________

Responsible Party Signature: ____ **Date:** ___________________

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to ENT and Allergy Associates for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to ENT and Allergy Associates for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. ENT and Allergy Associates, LLP will not be involved with separation or divorce disputes.

  You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment form you, you will be additionally responsible for whatever charges we incur as a result of this.

  WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

  THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient's Name: ______________________________ DOB: ________________

Responsible Party Signature: ______________________________ Date: ________________

Print Name: ______________________________ Relationship: ______________