

Patient Name _____ Date of Birth _____

Why are you here today? _____

ALLERGIES: NONE
 Drugs Foods Seasonal

List Allergies _____

CURRENT MEDICATIONS: NONE
 Blood Thinners Aspirin Antibiotics Steroids

List Medications _____

PAST MEDICAL HISTORY: Have you ever had any of the following medical conditions?

BLEEDING PROBLEMS: NONE
 Bleeding Disorders: _____
 Deep Vein Thrombosis
 Blood Clots
 Anemia
 Other: _____

CANCER: NONE
 What kind? _____
 Where was it located? _____

ENDOCRINE/METABOLISM: NONE
 Diabetes
 Hyperthyroidism
 Hypothyroidism
 Other: _____

DIGESTIVE: NONE
 Gastric Reflux
 Intestinal problems: _____
 Gallstones
 Hepatitis
 Other: _____

NEUROLOGICAL PROBLEMS: NONE
 Alzheimer's
 Stroke
 Parkinson's Disease
 Seizures
 Other: _____

HEART DISEASE: NONE
 Angina / Chest Pain
 Pacemaker
 Arrhythmias
 High Blood Pressure
 Heart Attack
 Other: _____

ALLERGY/RHEUMATOLOGY: NONE
 Severe Allergic Reaction: _____
 Food Allergy
 Sjogren's Disease
 Other: _____

LUNG: NONE
 Asthma
 Emphysema
 Lung Problems: _____
 Other: _____

SKIN: NONE
 Eczema
 Other: _____

URINARY: NONE
 Bladder
 Kidney Problems: _____
 Other: _____

PAST SURGICAL HISTORY

- None
- Hernia
- Tonsillectomy/ Adenoidectomy
- Gallstones
- Sinus Surgery
- Heart Surgery
- Other: _____
- Ear Vent Tubes
- Ear Surgery
- Septoplasty
- Lung /Airway Surgery

- Complications with anesthesia?
- YES
- NO
- (If yes please explain) _____
- _____
- _____
- _____

CHILD SOCIAL HISTORY

- Are there pets in the home? Yes No
- Does the child live with both parents? Yes No
- Name of school attending: _____
- How does the child perform in school?
- Great Good Ok Poor
- Does either parent smoke? Yes No
- Does the child attend day care? Yes No
- Does the child attend school? Yes No

SOCIAL HISTORY

- Occupation _____
- Marital Status Single Married Divorced
- Tobacco Use (Smoke/Chew) Yes No
- Since what age have you smoked? _____
- Chewing Tobacco Yes No
- Intake of Alcohol Yes No
- Illicit Drugs Yes No
- Caffeine Intake Yes No
- Number of Children? _____

FAMILY HISTORY: What were the major medical problems, if any, of your parents, grandparents, siblings? (Mark all that apply.)

- Mother Living Deceased Health Problems _____
- Father Living Deceased Health Problems _____
- Siblings (___ Brother/s) Living Deceased Health Problems _____
- Siblings (___ Sister/s) Living Deceased Health Problems _____
- Children (___ Son/s) Living Deceased Health Problems _____
- Children (___ Daughter/s) Living Deceased Health Problems _____
- Aunt/s Living Deceased Health Problems _____
- Uncle/s Living Deceased Health Problems _____
- Grandmother Living Deceased Health Problems _____
- Grandfather Living Deceased Health Problems _____

CURRENT PROBLEMS: Please mark all appropriate responses to the following.

CONSTITUTIONAL: NONE

Fever

Fatigue

Weight Loss _____

Weight Gain _____

Other: _____

EYES: NONE

Blurred Vision Burning

Double Vision Itching

Eye Pain

Other: _____

EARS: NONE

Hearing Loss Ringing in Ears

Difficulty Hearing Pressure in Ears

Ear Pain Discharge from Ears

Dizziness / Vertigo

Other: _____

NOSE: NONE

Nosebleeds

Sinus Pressure

Nasal Congestion

Blockage / Obstruction

Runny Nose

Other: _____

MOUTH / THROAT: NONE

Sore Throat Mouth Ulcers

Bleeding gums Difficulty Swallowing

Snoring Painful Swallowing

Dry Mouth Post Nasal Drip

Oral Abnormalities Hoarseness

Other: _____

NEUROLOGIC: NONE

Fainting

Headaches

Seizures

Numbness

Weakness

Other: _____

CARDIOVASCULAR: NONE

Chest Pain

Murmur

Palpitations

Edema

Other: _____

LUNG: NONE

Wheezing

Shortness of Breath

Sputum Production

Snoring

Other: _____

DIGESTIVE: NONE

Vomiting

Heartburn

Loss of Appetite

Increased Appetite

Other: _____

SKIN / MUSCLES: NONE

Rash

Lumps

Bruise Easily

Muscle/ Joint Pain

Other: _____

This information has been reviewed with the patient. This information is complete and accurate to the best of my knowledge.

Patient Signature: _____

Physicians Signature: _____

PATIENT: Please print.

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Social Security Number _____ Birth date _____

Marital Status <i>(Please check one)</i>	Employment Status <i>(Please check one)</i>	Gender <i>(Please check one)</i>	Phone Contact Restriction
<input type="checkbox"/> Single	<input type="checkbox"/> Active <i>(Please list employer below)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Married	<input type="checkbox"/> Retired		
<input type="checkbox"/> Divorced	<input type="checkbox"/> Disabled	Pharmacy & Number _____	Okay to Leave Phone Message?
<input type="checkbox"/> Widowed	<input type="checkbox"/> Not Employed		<input type="checkbox"/> Yes <input type="checkbox"/> No

SPOUSE/DOMESTIC PARTNER:

Name _____ Home Phone _____ Cell Phone _____

CONTACT PERSON (Relative or friend [excluding spouse/domestic partner] to contact in case of emergency)

Name _____ Relationship _____ Phone Number _____

PHYSICIANS

Referring Physician _____ Referring Physician Phone _____

Primary Care Physician _____ Primary Care Physician Phone _____

PRIMARY INSURANCE

Name _____

Policy Holder *(If different from patient)* _____

SSN of Policy Holder _____

Birth Date (policyholder) _____

Policy # _____ Group # _____

SECONDARY INSURANCE

Name _____

Policy Holder *(If different from patient)* _____

SSN of Policy Holder _____

Birth date (policy holder) _____

Policy # _____ Group # _____

FINANCIAL AGREEMENT, ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

Please read and sign the following consents, releases, and agreements:

1. **RELEASE OF INFORMATION:** To obtain payment for services, the undersigned hereby authorizes the clinic to furnish from the patient's record requested information or excerpts to any insurer, employer or union which processes claims for the patient's care.
2. **PAYMENT AUTHORIZATION:** I authorize payment directly to Northwest ENT and Allergy, P.C. of all benefits otherwise payable to me or for my benefit by reason of any insurance policies, and I hereby irrevocably assign such benefits to Northwest ENT and Allergy, P.C. in an amount, however, not to exceed the charges for the services rendered above. I agree to be financially responsible for charges not covered by insurance. If my indebtedness for such charges is placed with an attorney or agency for collection, I agree to pay Northwest ENT and Allergy, P.C. reasonable attorney's fees and collection expenses.
3. All appointments must be canceled 24 hours prior to scheduled appointment time. Appointments that are not canceled 24 hours prior to scheduled appointment time will be charged a \$50.00 cancellation / No Show Fee.

Signature of Patient or Person Assuming Financial Responsibility *(if other than patient)* _____

Date _____



LIFETIME AUTHORIZATION

Authorization Period: _____ From: _____ To: _____

"I request that payment under the medical insurance program be made either to me or to the provider named above on my bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any Medicare claim. I further permit a copy of this authorization to be used in place of the original."

Signature of Patient or Person Assuming Financial Responsibility (if other than patient) _____ Date _____

If Patient's Representative, signed on behalf of: _____
Please Print Name of Patient Representative

Description on representative's Authority: _____

Attach documentation of legal authority, if Legal Guardian or Holder of Power of Attorney.

CONSENT TO RELEASE HEALTH INFORMATION

Patient Last Name _____ Patient First Name _____ Date of Birth _____

As a patient of NW ENT & Allergy, P.C., I understand that NW ENT & Allergy, P.C., will use, disclose, store and maintain health information about me. I understand that my health information may include information that is created or received by NW ENT & Allergy, P.C., may in the form of written or electronic records spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By my signature or that of my representative below, I agree and understand that NW ENT & Allergy, P.C., may use and disclose my health information for such typical purposes of:

- Treatment**, including providing, coordinating, managing, making decisions about and panning for my care and treatment: referring to, consulting with, coordinating among, and managing along with other health care providers for my car and treatment.
- Payment**, including determining my eligibility for health plan or insurance coverage and benefits, submitting bills to health plans, insurers and other who may be responsible to pay for some or all of my health care; and
- Health Care Operations**, including performing various office, administrative, and business functions that support NW ENT & Allergy, P.C.'s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

During the course of your therapy, it is fairly common for frequent communication with a friend or family member to take place either in the office or by telephone. Please authorize the staff to release information to specific family member, friend or care giver.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by federal law to provide you with a description of how we may disclose your health information and of your rights regarding this information, including how you may obtain access to your own health information. This required description is known as a Notice of Privacy Practice and should be attached to this Acknowledgment form.

We must not only provide you with a copy of the Notice, but we must obtain your written acknowledgment verifying that you have received our Notice of Privacy Practices.

Therefore, please print your name and sign this Acknowledgment form in the spaces provided below indicating you have received a copy of our Notice of Privacy Practices.

By signing this form, you are verifying that we have provided you with our Notice of Privacy Practices.

By signing below, I consent to NW ENT & Allergy, P.C.'s uses and disclosures of my health information for the purposes of treatment, Payment, and Health Care Operations which include, but are not limited to, the purposes, or types of disclosures, described above.

Signature of Patient or Person Assuming Financial Responsibility (*if other than patient*) _____ Date _____

If Patient's Representative, signed on behalf of: _____
Please Print Name of Patient Representative

Description on representative's Authority: _____

Attach documentation of legal authority, if Legal Guardian or Holder of Power of Attorney.