amherst ent
Amherst Ear, Nose and Throat LLC

PATIENT INFORMATION FORM

***ENTIRE form MUST be filled in completely* (or it will be returned to you)**

FIRST NAME _____**Middle**_____ **LAST NAME** _____**AKA** _____

DOB _____**Age** _____ **M F Single**_____ **Married** _____ **Other** _____ **Minor** _____ **SSN#** _____

Address_____**City**_____ **State** _____ **Zip** _____

Cell #_____ **Home #** _____**Work#**_____

Employer _____**Occupation**_____ **Student** ☐

E-Mail_____

Responsible Party (if minor)

Name: _____Relation: _____ DOB: _____

Address (if different): _____ Phone #: _____ E-Mail _____

INSURANCE INFORMATION

Primary Insurance:_____**Policy ID#** _____**Group#**_____

Policy Holder Name: _____DOB:_____

Address (if different): _____

Secondary Insurance:_____Policy ID #_____Group#_____

Policy Holder Name: _____DOB:_____ Address (if different) _____

Primary Doctor (Name, Address & Phone) _____

Referring Doctor (Name, Address & Phone) _____

Pharmacy Name (Name, Address & Phone) _____

In Case of Emergency

Contact: _____ Relationship:_____ Cell #_____Home # _____Work # _____

List contact(s) you authorize us to discuss your private medical information with.

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

****PLEASE READ** My signature below serves as my acknowledgment of Amherst ENT's HIPAA Privacy Policy & Financial Agreement which is posted on their website, in the waiting room & on the patient clip board. Medicare & Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical and/or surgical benefits to Amherst Ear, Nose & Throat for any services furnished. I am aware that once my claim is submitted to my insurance company, additional charges might accrue for certain procedures (these procedures include, but are not limited to, audiograms, tympanograms, nasal endoscopies, laryngoscopies and biopsies). I am aware that it is the patient/parent/guardian responsibility to know what is covered under the insurance plan. I understand that I am financially responsible for any amount not covered by my insurance. I am aware that Amherst ENT does not participate with workers compensation or No-Fault Insurance and will not submit a claim on my behalf. The information above is accurate to my knowledge.**

Patient/Parent/Guardian Signature _____**Date** _____

Today's Date: _____

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PATIENT NAME_____DOB _____

What medical problem brings you here? _____

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **NONE**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

MEDICAL HISTORY **Have you ever been diagnosed with any of the following problems?**

Diabetes	☐ **Yes**	☐ **No**	**Liver**	☐ **Yes**	☐ **No**
Kidney	☐ **Yes**	☐ **No**	**Hepatitis**	☐ **Yes**	☐ **No**
Bruising Easily	☐ **Yes**	☐ **No**	**Vision**	☐ **Yes**	☐ **No**
Sleep Apnea	☐ **Yes**	☐ **No**	**Stroke**	☐ **Yes**	☐ **No**
Bladder	☐ **Yes**	☐ **No**	**Heart**	☐ **Yes**	☐ **No**
Thyroid	☐ **Yes**	☐ **No**	**High Blood Pressure**	☐ **Yes**	☐ **No**
Stomach	☐ **Yes**	☐ **No**	**High Cholesterol**	☐ **Yes**	☐ **No**
Intestinal	☐ **Yes**	☐ **No**	**Mitral Valve Prolapse**	☐ **Yes**	☐ **No**
Bleeding Disorders	☐ **Yes**	☐ **No**	**Lung**	☐ **Yes**	☐ **No**
Blood Problems	☐ **Yes**	☐ **No**	**Asthma/Bronchitis**	☐ **Yes**	☐ **No**

Other medical condition(s) not mentioned above? _____

PAST SURGERY (List ALL & Include Dates) _____

☐ **NO PAST SURGERY**

FAMILY HISTORY (immediate)

Hearing Loss	☐ No ☐ Yes who? _____	Bleeding Problems	☐ No ☐ Yes who? _____
Ear Surgery	☐ No ☐ Yes who? _____	Reaction to Anesthesia	☐ No ☐ Yes who? _____
Allergies	☐ No ☐ Yes who? _____	Malignant Hyperthermia	☐ No ☐ Yes who? _____

SOCIAL HISTORY

Do you now or have you ever used tobacco? ☐ No ☐ Yes
What kind? _____ How much per day? _____For how long? _____Quit how long ago? _____
Do you live or work in a smoking environment? ☐ No ☐ Yes
Do you now or have you ever consumed alcohol? ☐ No ☐ Yes ☐ Socially

ALLERGY TO MEDICATION ☐ No Known Allergies _____

Do you have a LATEX Allergy? ☐ No ☐ Yes If yes, please explain reaction_____

HEIGHT_____ WEIGHT _____

REVIEW OF SYSTEMS **Check any of the following problems you have recently encountered**

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General health problems
☐fatigue ☐excessive sleepiness ☐ weight loss ☐sleeping difficulties ☐chills ☐ fever ☐ night sweats ☐weight gain

Eye problems
☐double vision ☐itchy eyes ☐swelling ☐redness ☐decreased vision ☐ watery ☐ pressure ☐ dry eye

Ear problems
☐ear drainage ☐hearing loss ☐ear infections ☐dizziness ☐itchy ☐ear sores ☐ringing /noise in ears ☐ear pain ☐earache ☐plugged ear

Nose & Sinus problems
☐chronic congestion ☐mouth breathing ☐snoring ☐frequent sneezing ☐runny nose ☐post-nasal drip ☐nosebleeds ☐trouble breathing though nose ☐snorting ☐ facial pressure ☐loss of smell ☐nasal discharge ☐sinus headache ☐sinus pain

Mouth & Throat problems
☐bad breath ☐snoring ☐choking ☐difficulty swallowing ☐gagging ☐hoarseness ☐feeling of something stuck in throat ☐sore throat ☐throat clearing ☐throat infections (strep, tonsillitis/other) ☐tongue lesions ☐cough ☐dry mouth

Cardiovascular
☐heart murmur ☐chest pains ☐palpitations ☐leg cramping ☐swelling of ankles ☐blacking out ☐ irregular heartbeat ☐edema ☐high blood pressure ☐orthopnea ☐palpitations ☐syncope

Lung or respiratory problems
☐shortness of breath ☐wheezing ☐cough ☐croup ☐difficulty breathing ☐noisy breathing ☐ stops breathing ☐ dyspnea ☐ hematemesis ☐pleurisy ☐snoring ☐stridor

Gastrointestinal
☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting ☐frequent burping ☐constipation ☐GERD ☐hematemesis ☐melena

Neurological
☐seizures ☐unclear speech ☐dizziness ☐difficulty with balance ☐weakness ☐numbness ☐vertigo ☐headache ☐tremors

Musculoskeletal
☐joint pain ☐joint swelling ☐muscle weakness

Psychological
☐ADHD ☐eating disorder ☐psychiatric treatment ☐anxiety ☐depression ☐insomnia

Blood or Lymph nodes problems
☐bleeds excessively after injury ☐bruises easily ☐sickle cell anemia ☐swollen glands ☐anemia

Endocrine
☐cold intolerances ☐diabetes ☐excessive thirst ☐goiter ☐heat intolerances ☐polyuria

Allergy problems
☐food intolerances ☐hay fever ☐hives ☐asthma

Skin
☐rash ☐itchy ☐latex allergies ☐swelling ☐hives ☐bruising ☐eczema ☐red spots

Head/Neck
☐headaches ☐masses in neck ☐swelling ☐injuries, if so when? _____

☐ **No problems listed above**

Patient/Guardian Name (print) _____Date _____