



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 # _____

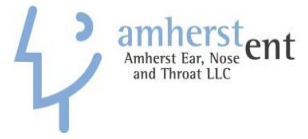
List contact(s) you authorize us to discuss your private medical information with.

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: _____



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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bruising Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bladder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stomach | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Intestinal | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma/Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other medical condition(s) not mentioned above? _____

PAST SURGERY (List ALL & Include Dates) _____

NO PAST SURGERY

FAMILY HISTORY (immediate)

- | | | | | | |
|--------------|-----------------------------|---|------------------------|-----------------------------|---|
| Hearing Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ | Bleeding Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ |
| Ear Surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ | Reaction to Anesthesia | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ |
| Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ | Malignant Hyperthermia | <input type="checkbox"/> No | <input type="checkbox"/> Yes who? _____ |

SOCIAL HISTORY

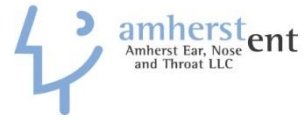
- Do you now or have you ever used tobacco? No Yes
 What kind? _____ How much per day? _____ For how long? _____ Quit how long ago? _____
 Do you live or work in a smoking environment? No Yes
 Do you now or have you ever consumed alcohol? No Yes Socially

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



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 through 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** _____