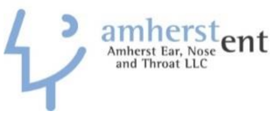


PATIENT INFORMATION FORM

****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 also certify that the information above is accurate to my knowledge.**

Patient/Parent/Guardian Signature ____**Date** ________________________________

amherst ent
Amherst Ear, Nose and Throat LLC

PEDIATRIC MEDICAL HISTORY

PATIENT NAME ____ _DOB_______________Age __________

What medical problem brings your child here? ____

LIST ALL CURRENT MEDICATIONS BEING TAKING (Prescription or over-the-counter) ☐ None

Medication	Dosage	How often taken		Medication	Dosage	How often taken

ALLERGY TO MEDICATION ____ ☐ None

ENVIRONMENTAL ALLERGY ☐ YES ☐ NO ☐ UNSURE

CHILDHOOD ILLNESSES ☐ None ☐ Croup ☐ Bronchiolitis ☐ Infant reflux ☐ RSV ☐ Mononucleosis

☐ Premature Birth/How Early? ____________________ ☐ Other _______________

CHRONIC MEDICAL PROBLEMS ☐ None ☐ Allergies ☐ Asthma ☐ Bleeding Problems ☐ Bladder

☐ ADHD ☐ Depression ☐ Diabetes ☐ Heart Condition

☐ Epilepsy/Seizures ☐ Birth Defect ___________________________

☐ Cancer __________________

☐ Other ___________________________________

PAST SURGERIES (include dates) ☐ None ____

Does your child have any problem with Anesthesia? ☐ YES ☐ NO ☐ UNSURE (child never had surgery)

If yes, please explain ____

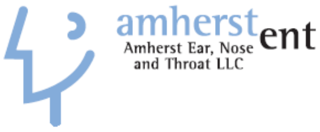
FAMILY HISTORY- Does anyone in the immediate FAMILY (not the patient) have any of the following:

Severe reaction to anesthesia	☐ YES	☐ NO	Bleeding problems	☐ YES	☐ NO
Hearing loss	☐ YES	☐ NO	Acid reflux	☐ YES	☐ NO
Allergies	☐ YES	☐ NO	Asthma	☐ YES	☐ NO

Is child exposed to environmental tobacco smoke? (second hand smoke) ☐ YES ☐ NO If Yes, Explain _________________

Has the child had any exposure to tobacco smoke in the perinatal period? ☐ YES ☐ NO

Height _______________Weight __________________ Todays Date ______________



REVIEW OF SYSTEMS: **Check any of the following problems your child has had within the last 6 months:**

General health problems
☐fatigue ☐excessive sleepiness ☐ frequent night awakenings ☐weight loss ☐sleeping difficulties ☐weight gain

Eye problems
☐double vision ☐itchy eyes ☐swelling ☐redness

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

Nose & Sinus problems
☐chronic congestion ☐mouth breathing ☐snoring ☐frequent sneezing ☐runny nose ☐post-nasal drip ☐nosebleeds
☐trouble breathing though nose ☐snorting

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

Heart or circulation problems
☐heart murmur ☐chest pains ☐palpitations

Lung or respiratory problems
☐shortness of breath ☐wheezing ☐cough ☐croup ☐difficulty breathing ☐noisy breathing ☐ stops breathing

Gastrointestinal
☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting ☐frequent burping ☐constipation ☐difficulty feeding/eating

Brain or Nervous system problems
☐headaches ☐seizures ☐unclear speech ☐dizziness ☐numbness ☐developmental delays ☐difficulty with balance
☐behavior changes

Musculoskeletal
☐joint pain ☐joint swelling ☐muscle weakness

Psychological
☐ADHD ☐eating disorder ☐psychiatric treatment ☐social/behavior problems

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

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

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

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

☐ **NO PROBLEMS LISTED ABOVE**

Parent/Guardian Name (print): ____**Date** ______________