

## PATIENT INTAKE

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_  Home  Work  Cell Okay to Text?  Yes  No

Age \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  W  D  Sep SSN \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

## GUARDIAN OR SPOUSE INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

## EMERGENCY CONTACT (OUTSIDE OF HOUSEHOLD)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Other Phone \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

Patient  Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Other Physician—which one? \_\_\_\_\_

## RELEASE OF INFORMATION

STRICTLY CONFIDENTIAL

The ENT & Allergy Center has my permission to release MEDICAL information to the following:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

The ENT & Allergy Center has my permission to release BILLING information to the following:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_  Group  Self-Funded

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

## AUTHORIZATION AND ASSIGNMENT - INITIAL EACH OF THE FOLLOWING

\_\_\_\_\_ I have received a copy of the ENT & Allergy Center Compliance Final Patient Privacy rule part 164 HIPAA.

\_\_\_\_\_ I understand that it is my responsibility to notify the ENT & Allergy Center in writing of any changes to the above permissions.

\_\_\_\_\_ I hereby authorize ENT & Allergy Center to furnish information to Medicare and other insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY FORM

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

I consent to the email delivery of all information, including protected health information under HIPAA

## List your allergies to medicines:

No drug allergies       Penicillin       Sulfa       Codeine       Anesthetics  
 Other \_\_\_\_\_

## Race / Ethnicity

White       African / American       Hispanic       American Indian       European       Asian  
 Other \_\_\_\_\_

**Preferred Language**       English       Spanish       Other

## Do you take any medications?

Yes       No      If yes, please list \_\_\_\_\_

## Do you have the following?

Diabetes       Hypertension       Heart Disease

List any other medical conditions \_\_\_\_\_

## Do any of the following conditions run in your family?

Bleeding Tendency       Allergy Tendency       Diabetes       Hepatitis B       Hearing Loss       Heart Disease

## Alcohol / Tobacco Use:

Alcohol \_\_\_\_\_ oz / day       Smoke \_\_\_\_\_ packs / day       Smokeless Tobacco

**Do you have second hand smoke exposure?**       Yes       No      If yes, please check:       Home       Work       Social

**May we contact your pharmacy to get your medication history?**       Yes       No

**Preferred Pharmacy:** \_\_\_\_\_

List any surgeries you have had \_\_\_\_\_  None

## Do you have any of the following symptoms

Constitutional:	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss
Eyes:	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain
Heart:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Swelling in Legs
Lungs:	<input type="checkbox"/> Cough	<input type="checkbox"/> Spitting up Blood	<input type="checkbox"/> Shortness of Breath
GI:	<input type="checkbox"/> Nausea	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Difficulty Swallowing
Joint:	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Muscle Cramps or Weakness
Hematology:	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Lymph Node Enlargement
Skin:	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Cancer	
Psychiatric:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	
Allergy:	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Itching/Watery Eyes	

**I authorize and consent to my blood being tested for communicable diseases if any person is exposed to my blood or other bodily fluids at the ENT and Allergy Center.** \_\_\_\_\_ Date \_\_\_\_\_

# ANNUAL ALLERGY EVALUATION

Date \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

Since starting allergy shots, how much trouble are you having with:

	None	Mild	Moderate	Severe	Office use only
Nasal congestion and fullness					Provider recommendation:  Continue shots Schedule re-evaluation
Nasal blockage or mouth breathing					
Drainage out the front of nose					
Drainage down the throat					
Itching in the throat					
Itching/watery eyes					
Sneezing					
Cough					
Shortness of breath/asthma symptoms					
Headache					

Are you taking an antihistamine?  Yes  No *(check all tried)*

Zyrtec  Xyzal  Allegra  Claritin  Loratadine  Fexofenadine  Benadryl

Are you taking a nasal steroid?  Yes  No *(check all tried)*

Flonase  Nasocort  Nasonex  Rhinocort  Qnasl  Omnaris

Is the site of your injection red or swollen?  Yes  No

Do you feel that your allergy shots are helping you?  Yes  No

Are you happy with your level of allergy symptom control?  Yes  No

Would you like to continue injections?  Yes  No