

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 Bone
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