EAR
NOSE
THROAT
ENT and Allergy Center

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 and 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 _____

PATIENT PORTAL

To access the patient portal, go to www.entnwa.com and select patient resources. From this menu, choose patient portal and follow the prompts.

AUTHORIZATION AND ASSIGNMENT - INITIAL EACH OF THE FOLLOWING

_____ I have received a copy of the ENT and Allergy Center Compliance Final Patient Privacy rule part 164 HIPAA.

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

_____ I hereby authorize ENT and 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 _____

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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 ☐ Former Smoker

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

2100 N. Green Acres Rd, Fayetteville, AR 72703 • **(479) 521-0455**
www.entnwa.com