ENT and Allergy Associates of Florida – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name: _____ Date of Birth:_____ Age:_____

Sex: F____ M ____ Marital Status: M ___ S___ D ___ W___ Other___

Please check appropriate response:

* *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____

Native Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street *City,* *State* *Zip*

Patient's 2nd Address: _____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you?_____

Referring Physician_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ ____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth _____ID#_____Group#_____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to *ENT and Allergy Associates of Florida*. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and ENT and Allergy Associates of Florida to photograph me for medically related documentation purposes. Yes_____ No_____

Signature: _____ Date:_____

ENT and Allergy Associates of Florida

Caring For Our Patients Since 1963

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ M or F

Referring Physician: _____ *Pharmacy Name _____

*Pharmacy Cross Street _____

*Pharmacy Phone Number _____

Primary Care Physician: _____ **Weight:** _____ **Height:** _____

Briefly, why are you seeing our physician today? _____

1. **Patient History -** Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	( )	( )	Nasal: Allergies	( )	( )
Heart (enter details below)	( )	( )	Nasal: Nasal Trauma	( )	( )
Cardio: Hypertension	( )	( )	Nasal: Nose Bleeds	( )	( )
Ear: Dizziness	( )	( )	Nasal: Sinusitis	( )	( )
Ear: Hearing Loss	( )	( )	Neuro: Headaches/Migraines	( )	( )
Ear: Tinnitus Ringing in Ear	( )	( )	Neuro: Nervous System	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	*Oral: Sleep Apnea*	( )	( )
G.I.: Liver Disorders	( )	( )	Pysch:PsychiatricDisorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )	Pulm: Lungs	( )	( )
G.I.: Reflux GERD/Heartburn	( )	( )	Pulm: Tuberculosis	( )	( )
Immuno: HIV	( )	( )	Uro:Bladder Disorders	( )	( )
Immuno: Immune Dieases	( )	( )	Uro: Kidney	( )	( )
Lymph: Anemia	( )	( )			
Lymph: Bleeding Disorders	( )	( )			

Other: _____

Details of Yes answers: _____

_____

2. **Surgeries -** Please list any surgeries/hospitalizations: _____

_____

3. **Social History -** Are you a current smoker? (Y or N) You now smoke _____packs of cigarettes a day.

You smoked _____packs per day and quit _____years ago.

You consume _____alcoholic beverages per day / week / month (circle).

How many caffeinated beverages do you drink per day? _____

4. **Family History -** Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers: _____

Patient Signature: _____ Date: _____

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Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ No Known Drug Allergies

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please check response: ☐ **Yes** ☐ **No**

Patient/Guardian Signature: _____

Print Patient Name: _____ **D.O.B:**_____