

ENTOffice.org, PLLC Medical History Form Today's Date: ___/___/___

*** Please complete ALL the information; if Not Applicable, please write "N/A" ***

Patient's Name: _____ **Date of Birth:** ___/___/___

Person Completing Form and how you are related to the patient: _____

(if you are the patient, write "self")

When was your first visit with ENTOffice.org? _____

Regular (primary) Doctor: _____

How did you hear about ENTOffice.org? _____

If another doctor referred you, what is his or her name? _____

Why are you here today? _____

Medicines:

Do you take any medicines? **Yes** **No**

If "Yes", what do you take and when do you take them?

<u>Name and strength</u>	<u>Do you take it every day?</u>	<u>How many times a day?</u>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Do you have allergies to any medicines? **Yes** **No**

If "Yes", what are they? _____

Explain what happens when you have a bad reaction to medicine:

If there is a pharmacy where you want to get your medicine, tell us where:

_____ (name and where it is)

Tobacco

Do you use tobacco? **Yes** **No** What type? _____ How much? _____

When did you start? _____ If you quit, how long ago? _____

Alcohol

Do you drink alcohol? **Yes** **No** If yes, how much? _____

Could you be pregnant now? **Yes** **No** **Not sure**

Has the patient ever had or been treated by a doctor for any of the following

General	Yes	No		Yes	No
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Mucus production	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart		
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Ear			Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to loud sound	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestines		
Ringing ears/tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infection	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or belching	<input type="checkbox"/>	<input type="checkbox"/>
Eye			Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow skin/eyes)	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	Joints		
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (joint pain/swelling)	<input type="checkbox"/>	<input type="checkbox"/>
Lymph			Blood		
Large lymph "glands"	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/clotting problems	<input type="checkbox"/>	<input type="checkbox"/>
Nose			Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections (that keep coming back)	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health		
Allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mouth			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Different sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	Sleep		
Throat			Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Scratchy voice	<input type="checkbox"/>	<input type="checkbox"/>	Gasping/choking (during sleep)	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Brain		
Difficult swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Neck			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Painful neck swelling	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (many times)	<input type="checkbox"/>	<input type="checkbox"/>
Painful neck movement	<input type="checkbox"/>	<input type="checkbox"/>	Light-headed	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid mass / swelling	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Lungs			Weakness or can't move	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Surgery		
Coughing/spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>

Medical History— Please check “Yes” if the patient has EVER had any of these problems

	Yes	No		Yes	No
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	COPD (lung disease)	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
Cancers	<input type="checkbox"/>	<input type="checkbox"/>			

Are you (the patient) having any of these problems RIGHT NOW? If yes, what?

Please tell us all the operations you have had (and when):

What: (ex: tonsils out)

When: (ex: 2007 or 10 years ago)

FAMILY: Has a relative (by blood) ever had any of these problems?

	Yes	No		Yes	No
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Long term ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Long term sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Snoring or sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
			Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
			other _____		

If you answer “yes” to any of these, tell us who it was by writing next to the problem: GG (great-grandparent), G (grandparent), P (parent), S (sibling), C (child)

Is there anything else we should know?

ENTOffice.org, PLLC Patient Registration Form Today's Date: ___/___/___

You:

Patient's Name: _____ Date of Birth: ___/___/___

Your Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____

Please allow us to contact you by Email: _____

Sex: Male Female Other Social Security Number: _____-____-_____

Are you Hispanic or Latino? **Yes** **No**

Race:

American Indian/Alaskan Native

Native Hawaiian/Pacific Islander

Asian

White

Black/African American

Education/Employment:

If you (the patient) are a student: School Name: _____ Grade: _____

If you (the patient) work: Employer: _____ Phone: () _____

INSURANCE INFORMATION

*****We will make a copy of insurance card and photo ID to help prevent insurance fraud*****

Insurance Company: _____ Phone () _____

Member Number #: _____ Group #: _____

Effective Date: _____

Is the insurance in your name? Yes No If NOT, whose name is it under?

His/Her name: _____ Date of Birth: ___/___/___

Sex: Male Female Other Social Security Number: _____-____-_____

Who can we call in case of an emergency?

Name: _____ Phone () _____

Permission to Use and Share Health Information for Treatment, Payment, or Additional Care

I understand...

- As part of my care, ENTOffice.org creates and keeps my health record. This record includes my health history, why I am being seen as a patient at ENTOffice.org, what I talk about with the doctor, nurse, or medical assistant, any tests I have done, and what the doctor plans for my treatment.
- I am giving permission for my insurance company to pay ENTOffice.org for any surgical and/or medical benefits available to me under my current insurance plan.
- I know that (unless I am covered by Medicaid) I am responsible for the part of my bill insurance does not cover.
- Due to individual policies and plans, treatment may be subject to deductible and/or coinsurance. By signing this agreement, I acknowledge I am responsible for these charges.
- I have certain rights to privacy about my health information. This is because of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by signing this form I give permission for ENTOffice.org to use and share my protected health information to do the following:
 - Treatment (the action, medicine, or therapy) ordered by the doctor
 - Talk with other doctors or people responsible for my care
 - Getting payment from my insurance company
 - Showing my insurance company what the doctor did at my visit
 - Making sure ENTOffice.org can measure the ability and effectiveness of the doctors, nurses, and medical assistants.
- ENTOffice.org has the right to change the terms of this notice from time to time and that I may contact you at any time to get the most current (up to date) copy of this form and the Notice of Privacy Policies.
- I have the right to ask for changes to (or limitations on) how my protected health information is used and shared in order to treat me, collect payment, and carry out other health care actions.
- ENTOffice.org is NOT required to agree to the changes I ask for. However, if ENTOffice.org does agree, it must follow the changes I ask for.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Policies, which:

- Has a better description of the uses and sharing of my protected health information,
- Talks about my rights under HIPAA.

I understand that I may cancel or take back this permission, in writing, at any time. However, any use or sharing of my information that happened before I take back permission is not changed.

Date _____

Print Patient Name _____

Relationship to Patient _____

Signature _____

Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

On the other hand, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

- If an appointment is not cancelled at least 24 hours in advance you may be charged a twenty-five dollar (\$25) fee; this will not be covered by your insurance company.
- If you no-show (do not show up) to an appointment without notifying us, you may be charged a twenty-five dollar (\$25) fee; this will not be covered by your insurance company.
- If you no-show to an appointment more than one time, we may send a note informing your regular doctor (PCP) and we will ask that you establish care somewhere else.

2. Late Arrival for Scheduled Appointments

We understand that delays can happen, but we must try to keep the other patients and doctors on time.

- If you arrive 15 minutes after your scheduled appointment time you may need to reschedule the appointment.
- If you are late to your appointment 3 or more times, we may inform your regular doctor (PCP) and ask that you establish care somewhere else.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. This also prevents other patients from receiving necessary care/treatment.

- If surgery is not cancelled at least 48 hours in advance you may be charged a one hundred dollar (\$100) fee; this will not be covered by your insurance company.

Patient Name (PRINT) : _____

Patient Signature: _____ Date: _____