

WHITE ROCK ENT PATIENT INFORMATION SHEET

Doctor _____ Date _____
Last Name _____ First _____ Middle I _____ Sex ___M___F
Address _____ Apt. _____ City/ST _____ Zip _____
Home Phone _____ Cell Phone _____ Soc. Sec. _____
Drivers License# _____ Age _____ Date of Birth _____
Employer-If Minor give Parent's Information _____ Work Phone _____
Name of Spouse _____ Work Phone _____
Person to Contact in Emergency (other than Spouse)

Phone _____
Referring Physician _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT: (if different from above or if child is a minor and/or full time student)

Last Name _____ First _____ Middle I _____
Address _____ City/ST _____ Zip _____
Home phone _____ Work phone _____
Relationship to Patient _____ Birthdate _____ Soc. Sec. _____ Driver license# _____

HEALTH INSURANCE INFORMATION (If you are unable to provide an Insurance Card and Required referral at time of service, payment will be required in full.)

Primary Insurance Co. _____ Name of Insured _____

Social Security# _____ Birthdate _____ Relationship to insured _____

Send Claim to: _____ City _____ State _____ Zip _____

ID# _____ Group# _____

Secondary Insurance Co. _____ Name of Insured _____

Social Security# _____ Birthdate _____ Relationship to insured _____

Send Claim to: _____ City _____ State _____ Zip _____

ID# _____ Group# _____

Authorization and Assignment (Must read and sign)

I authorize you to give me reasonable and proper medical care by today's standards.
I hereby authorize White Rock ENT to release all medical information or any information required by my insurance company and others to file for medical benefits or otherwise collect on my account.
I authorize payment of all benefits to the physician(s).

Date

Signature

THIS FORM MUST BE COMPLETED TO BE SEEN

PATIENT HISTORY FORM (please write legibly)

Patient's Name: _____ DOB _____ Date: _____

Describe Illness/Condition: _____

When did it begin? _____

List any current/past treatment? _____

List Xray/CTscan/Labwork _____

PAST MEDICAL HISTORY: (Circle condition)

- | | |
|-----------------------------------|--------------------------------|
| Allergic rhinitis | High blood pressure |
| Anaphylactic reaction to medicine | High cholesterol |
| Anemia | HIV/AIDS |
| Angina/heart attack | Irregular heart beat/pacemaker |
| Arthritis conditions | Radiation therapy |
| Asthma | Reflux |
| Blood clotting abnormalities | Renal failure / insufficiency |
| Cancers/tumors | Respiratory failure |
| Congestive heart failure | Seizure disorders |
| COPD/emphysema | Sleep apnea |
| CPAP | Stroke |
| Depression | Thyroid disease |
| Diabetes | Tuberculosis |
| Hepatitis | Ulcers |
| Hiatal hernia | NOT APPLICABLE |
| OTHER NOT LISTED _____ | |

MEDICATIONS: (List each Medication and what's it for; write NA if on no medications)

Name of Medicine	Condition it's for
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY: (Circle Surgeries Patient has had)

- | | |
|-------------------------------------|--|
| Angioplasty | Joint replacement |
| Appendectomy | Mastectomy |
| Back surgery | Prostate surgery |
| CABG (coronary Artery Bypass Graft) | Rhinoplasty |
| Cancer surgery | Septoplasty |
| Cholecystectomy | Sinus surgery |
| C-section | Thyroidectomy |
| Eardrum repair | Tonsillectomy / adenoidectomy |
| Ear Tubes | Tubal ligation |
| Eye surgery | Vascular surgery [Aorta, Leg, Carotid] |
| Hemorrhoidectomy | NOT APPLICABLE |
| Hernia repair | |
| Hysterectomy | |
| OTHERS NOT LISTED _____ | |

REVIEW OF SYSTEM

Do you (PATIENT) complain of any of the following? (*Circle what applies*)

- Asthma attack or wheezing
- Bleeding tendency and easy bruising
- Chronic cough
- Confusion, disorientation and/or poor memory
- Coughing up blood
- Crushing sensation in chest and/or left arm pain
- Daytime sleepiness
- Depression
- Difficulty [choking]/or pain with swallowing
- Dizziness and/or faintness spells
- Extreme thirst/frequent urination
- Eyes itching/watering
- Fever and/or chills and/or night sweats
- Headaches/migraines
- Hearing loss and /or noise in ears/head
- Heart palpitations (racing)
- Heartburn
- Joint pain, swelling and/or redness
- Loss of vision [right,left,both]
- Lost sense of smell and /or taste
- Nasal drainage, odor and/or postnasal drainage
- Nasal itching, congestion/clear discharge
- Nausea and/or vomiting
- Nose bleeds, bloody nasal discharge
- Paralysis/weakness of [arm,leg,face]
- Recent exposure to tuberculosis
- Recent seizures
- Regurgitation of food or blood
- Seasonal allergies/hay fever
- Shortness of breath or easy fatigue with exertion
- Sleep problems
- Sneezing after meals/exposure to cold air
- Snoring
- Sore throats
- Swelling of ankles and legs
- Swollen lymph nodes
- Tiredness/fatigue
- Weight gain/or loss

NOT APPLICABLE

MEDICATION ALLERGIES (*Circle the medicine*)

- | | |
|--|-----------------------|
| Ampicillin / Penicillin | Morphine |
| Aspirin / NSAIDS | Novocaine |
| Cephalosporins | Prednisone / steroids |
| Codeine | Sulfa drugs |
| Dairy products | Tetanus vaccine |
| Demerol | Tetracycline |
| Erythromycin | NOT APPLICABLE |
| Iodine / radiographic dye / shell fish | |
| Latex | |

Others Not Listed: _____

Alcohol use-number of drinks/week: (_____/week)

In Daycare

In School

Married

Single

Widowed

Domestic partnership

Lives with parent/guardian family

Tobacco use: How many packs/day_____? How many years?_____

When did you quit?_____ Chew tobacco? If so, how many years?_____

FAMILY MEDICAL HISTORY (Circle what applies)

Alcoholism

Allergic problems

Anesthesia problems

Asthma

Bleeding disorders

Cancers

Diabetes

Hearing loss

Heart disease

High cholesterol

Hypertension

Stroke

Thyroid disorders

NOT APPLICABLE

OTHERS NOT LISTED_____

PATIENT'S VITAL STATISTICS

AGE: _____

SEX: _____

WEIGHT: _____

HEIGHT: _____

NOTICE OF CONFIDENTIALITY

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If you have received this document/email/fax in error please notify the sender and destroy the message immediately. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this document/email/fax.

White Rock ENT

1. Insurance cards and a valid driver's license are required to file your insurance. If you do not have them you will need to pay for your office visit in full.
2. If your insurance requires a referral it is your responsibility to obtain it from your primary care physician. We must have it in our office before services are rendered.
3. If you do not arrive at your appointment time – you have lost that appointment. We require 24 hour notice for cancellations and reschedules. A \$25.00 fee may apply.
4. Co-payment and/or Deductibles are due at the time services are provided.
5. All minors (under 18 years of age) must be accompanied by a parent or legal guardian at the time service is provided.
6. Effective February 1st, 2008 all accounts turned over to a collection agency for outstanding balances will be responsible for the collection fee. The fee is 33% of the balance due.
7. Effective February 1st, 2008 any unpaid balance over 59 days (calculated from the time the insurance EOB is posted in the patient ledger) will accrue an interest of 10% until the unpaid balance is paid in full or turned over to a collection agency.
8. **ABSOLUTLEY NO FOOD or DRINKS IN THE OFFICE.**
9. Please contact your pharmacy to request any prescription refills, they will contact our office.
10. Release of medical information other than to the patient will not be permitted unless the patient signs a medical release. Please request this form from the receptionist.
11. Our physicians are ER Specialist – they may be called to the ER at anytime. Your patience is appreciated.
12. All FMLA, Disability or any other forms requiring the physician to complete must be given to the receptionist. There is a \$25.00 fee required for completion.
13. Our office files Primary and Secondary Insurance only.
14. No cell phone use in the waiting area or exam rooms.

I have read and agree to the above

Date