Ear Nose & Throat, Allergy, & Facial Plastic Surgery Specialists, LLC

Southport, CT

Patient Information: Minors & Dependents

PATIENT DEMOGRAPHICS

last name	first name	middle initial	age (years)

address (street or P. O. Box)	(apt. #)

city	state	zip code	home telephone #:

cell phone #	email address

date of birth (MM/DD/YR)	m	f	social security #
/ /			- -

PARENTAL INFORMATION

please check one: ☐ single ☐ married ☐ divorced ☐ widowed

	parent #1	parent #2
name		
date of birth	/ /	/ /
social security #	- -	- -
employer		
employer address		
employer telephone #		
*home address: street		
*home address: city		
*home address: state/zip		
*home telephone #		
cell phone #		

* complete only if different from patient's home information

REFERRAL INFORMATION

whom may we thank for referring you to us?	relationship

street address

city, state, zip code

PRIMARY CARE PHYSICIAN

name	did your physician suggest an ENT consult?

office location

Please complete second side.

EMERGENCY INFORMATION

name of nearest relative not living with you	relationship
address	telephone #
whom may we contact in case of an emergency?	relationship
address	telephone #

INSURANCE INFORMATION (please provide your insurance card to the receptionist)

	primary insurance	secondary insurance
company		
address		
policy number		
policy holder's name		

I hereby authorize payment of benefits directly to Ear Nose & Throat, Allergy, & Facial Plastic Surgery Specialists, LLC otherwise payable to me for medical and/or surgical services rendered. I realize that I am responsible for payment of any non-covered service, co-payment or deductible. I am aware that delinquent accounts will be charged interest. In addition, I agree to pay any costs of collection including 33% collection fee and/or reasonable attorney fees.

I also hereby authorize Ear Nose & Throat, Allergy, & Facial Plastic Surgery Specialists, LLC to furnish information concerning illnesses and treatments of the above named patient to any third party payor with whom the patient is under contract.

I hereby permit the doctor or his assistant to take photographs of the above named patient. I understand that these photographs are for legal documentation or presentation at professional meetings and discussions, and I give permission to use them as such.

signature of parent or guardian	date

Patient Name: DOB:

Patient Medical History Form (p.1) **Please provide the following medical information to the best of your ability:**

Date:	Age:	List any ALLERGIES TO MEDICATIONS:
What are your concerns for today's visit?		

Past Medical History:

1) Please check the "Yes or "No" box to indicate whether you have any of the following illnesses; for "Yes" answers, please explain.

	Yes	No	
Diabetes	☐	☐	
Hypertension (high blood pressure)	☐	☐	
Thyroid Problems	☐	☐	
Heart Disease/Cholesterol Problems	☐	☐	
Respiratory Problems	☐	☐	
Stomach or Intestinal Problems	☐	☐	
Allergy Problems/Therapy	☐	☐	
Kidney Problems	☐	☐	
Neurological Problems	☐	☐	
Other Medical Diagnosis	☐	☐	

2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):

3) Please list any current medications (and amounts, times per day);
(including aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History:

	Yes	No	Please list details below:
Do you smoke? List how much.	☐	☐	
If no, did you smoke previously?	☐	☐	
How often do you drink alcohol?			
What type of alcohol do you prefer?			
What is your occupation?			

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:

If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing Problems	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding Disorder	☐	☐	
Anesthesia Problems	☐	☐	
Heart Problems	☐	☐	

Reviewed by:

Date: ____/____/____

Patient Name: DOB:

Patient Medical History Form (p. 2): **Please provide the following medical information to the best of your ability:**

Review of Systems:

1) Please check the "Yes" or " No" box to indicate whether you presently have any of the following symptoms:
2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
ALLERGY	sneezing	☐	☐	☐	post-nasal drip	☐	☐	☐
	environmental allergy	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	dizziness	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	sense of smell problem	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
EYES	eye pain	☐	☐	☐	watery or itchy eyes	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
NEURO	headache	☐	☐	☐	passing out	☐	☐	☐
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

PLEASE STOP HERE

Reviewed by: