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?

Name and strength	Do you take it every day?	How many times a day?
	Yes □ **No** □	
	Yes □ **No** □	
	Yes □ **No** □	

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**
Chills	□	□
Fatigue	□	□
Fever	□	□
Night sweats	□	□
Ear		
Hearing loss	□	□
Sensitive to loud sound	□	□
Ringing ears/tinnitus	□	□
Recurrent ear infection	□	□
Eye		
Double vision	□	□
Eye pain	□	□
Sensitivity to light	□	□
Vision changes	□	□
Lymph		
Large lymph "glands"	□	□
Nose		
Nosebleeds	□	□
Sinus infections (that keep coming back)	□	□
Allergy symptoms	□	□
Mouth		
Different sense of taste	□	□
Throat		
Scratchy voice	□	□
Recurrent sore throats	□	□
Difficult swallowing	□	□
Neck		
Painful neck swelling	□	□
Painful neck movement	□	□
Thyroid mass / swelling	□	□
Lungs		
Cough	□	□
Shortness of breath	□	□
Coughing/spitting up blood	□	□
Wheezing	□	□
Mucus production	□	□
Heart		
Palpitations	□	□
Chest pain	□	□
Leg swelling	□	□
Stomach/Intestines		
Nausea/vomiting	□	□
Heartburn or belching	□	□
Abdominal pain	□	□
Hepatitis A/B/C	□	□
Jaundice (yellow skin/eyes)	□	□
Joints		
Arthritis (joint pain/swelling)	□	□
Blood		
Bleeding/clotting problems	□	□
Easy bruising	□	□
HIV/ AIDS	□	□
Mental Health		
Depression	□	□
Anxiety	□	□
Sleep		
Snoring	□	□
Gasping/choking (during sleep)	□	□
Brain		
Dizziness	□	□
Fainting	□	□
Headaches (many times)	□	□
Light-headed	□	□
Loss of memory	□	□
Weakness or can't move	□	□
Seizures	□	□
Surgery		
Anesthesia problems	□	□

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

	Yes	No
Kidney disease	□	□
Liver disease	□	□
Stroke	□	□
Thyroid disorders	□	□
High cholesterol	□	□
Pneumonia	□	□
Tuberculosis	□	□
Cancers	□	□

	Yes	No
COPD (lung disease)	□	□
Diabetes	□	□
Heart disease	□	□
High blood pressure	□	□
Asthma	□	□
Other: _____		

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
Anesthesia problems	□	□
Long term ear infections	□	□
Long term sinus infections	□	□
Kidney disease	□	□
Hearing loss	□	□
Snoring or sleep apnea	□	□
Liver problems	□	□
Lung problems	□	□

	Yes	No
Stroke	□	□
Thyroid problems	□	□
Allergy	□	□
Tuberculosis	□	□
Cancer	□	□
Diabetes	□	□
Heart disease	□	□
High blood pressure	□	□
Bleeding problems	□	□
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?

_____

_____

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
□Asian
□Black/African American
□Native Hawaiian/Pacific Islander
□White

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.

By signing this I am also giving express consent to receive text or voice messages at the phone number on my registration sheet.

☐ **Check this box if you do NOT want to receive text or voice message reminders**

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: _____