

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Referring M.D. _____ Primary M.D. _____

Reason for today's visit: _____

Length of Problem: # of Days _____ #Weeks _____ #Months _____ #Years _____

Timing of Problem: Constant Intermittent Episodic Rare

Please Circle Severity of Problem: Mild Moderate Severe Intolerable

Are you (patient) ALLERGIC to any Medications? Please Circle YES NO. If yes, please list below the medication(s) and reaction:

List the medications you (patient) are currently taking and dosage: (please use back of page if needed)

PLEASE WRITE CLEARLY

Ex: Medication Name _____ Dosage of Medicine _____ How Often Med is Taken: _____

Review of Symptoms: (Please CIRCLE all that applies)

Constitutional Symptoms: fevers chills weight changes night sweats

Cardiovascular: chest pain palpitations orthopnea edema PND claudication exercise intolerance

Respiratory: shortness of breath wheezing cough hemoptysis sputum production

Eyes: blurred vision pain redness specks double vision glaucoma glasses/contacts

Ears: hearing loss ringing pain drainage

Nose: stuffy discharge bleeding sinus pain itching

Throat: sore tongue sore throat hoarseness dry mouth

Gastrointestinal: abdominal pain nausea vomiting diarrhea blood in stool

melena constipation heartburn Hx of ulcers appetite change dysphagia

Neurologic: dizzy fainting seizures tremors numbness tingling weakness memory loss headache

Endocrine: polyuria polydipsia heat/cold intolerance fatigue excessive sweating

Musculoskeletal: muscle pain joint pain joint instability

Genitourinary: dysuria frequency urgency hematuria nocturia incontinence penile/vaginal discharge

Skin: rash moles itching dryness lumps changing moles history skin cancer

Hematologic/Lymphatic: swollen glands easy bruising clotting problems

Psychiatric: depression anxiety excess stress nervousness

Allergy/Immunology: hay fever drug allergies food allergy venom

Gynecologic: menses: regular irregular clots dysmenorrhea menorrhagia PMS

Age at menarch _____ Age at menopause _____ Children Alive _____ Children Deceased _____

*If nothing applies above, please sign here: _____

SOCIAL HISTORY

Do you smoke now? _____ If so, how much? _____ How many Years? _____
Have you ever smoked? _____ How much? _____ How many years? _____ Year stopped? _____
Do you drink alcohol? _____ How much? _____ Do you drink every day? _____
What is/was your occupation? (if applicable) _____

FAMILY HISTORY

Do any of your close relatives have any of these conditions? If yes, please list relation:
(Includes: Father, Mother, Brother, Sister or others)

Bleeding Disorders? _____ Reactions to anesthesia? _____
Drug Reactions? _____ Fever with anesthesia? _____
Hereditary Disease? _____ Other: _____

SURGICAL HISTORY

List all surgeries by date and complications (if any):

ADDITIONAL INFORMATION

Please list any recent blood work, x-rays, CT scans, MRIs, swallowing studies, audiograms or important information that we need to know for your visit today and location where testing was done:

The above information was reviewed with the patient:

MD Signature

Date:

PATIENT REGISTRATION FORM

Patient Name: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Please Circle: Male / Female Age: _____ Birthdate: _____ SSN: _____

Email: _____ Employer: _____

Pharmacy: _____ Location (cross streets of pharm): _____

Out of State Address: _____ City: _____

State: _____ Zip Code: _____ Out of State Ph #: _____

If Patient is a Minor:

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

INSURANCE INFORMATION

Primary Policy Holder's Name: _____

Primary Policy Holder's D.O.B: _____ Relation to Patient: _____

SSN of Policy Holder: _____

Secondary Policy Holder's Name: _____

Secondary Policy Holder's D.O.B: _____ Relation to Patient: _____

SSN of Policy Holder: _____

Signature of Patient: _____ Date: _____

Shea ENT Clinic and Physician's Hearing Clinic

HIPAA –Patient Consent of Information and Financial Policy

Shea ENT Clinic & Physician's Hearing Clinic, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and the staff of Shea ENT Clinic and Physician's Hearing Clinic from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and phone # on a voicemail or with a live person answering the phone requesting the patient to return the phone call.

By completing the consent below, you are allowing Shea ENT Clinic and Physician's Hearing Clinic staff to leave a message on a machine/voicemail or with specified individuals. By signing, you are also consenting to the mailing, faxing or emailing of any results, requested by you to physicians of your choice.

I give my consent to Shea ENT Clinic and Physician's Hearing Clinic staff to leave a message regarding billing, appointments, surgery, lab results or other necessary information.

X	X	X
Print Patient Name	Signature of patient/parent	Date

People with Permission of whom to speak to with on my behalf

1) _____ relation: _____ ph: _____

2) _____ relation: _____ ph: _____

3) _____ relation: _____ ph: _____

I have been provided a copy of Shea ENT and PHC Privacy Practice (circle) **YES / NO**

I have declined a copy of Shea ENT and PHC Privacy Practice (circle) **YES / NO**

FINANCIAL POLICY

I understand that all copays, deductibles or co-insurance dictated by my insurance are my responsibility at the time of service. I also acknowledge that any fees incurred by Shea ENT Clinic or Physician's Hearing Clinic while in the process of collecting on a bad check or through a collection agency are my responsibility. By signing below you acknowledge and agree to the financial responsibilities.

X	X	X