Last Name: ______________________________ First Name: __________________________ MI: _______

Address: ________________________________ City: ___________________ State: _____ Zip: ________

Home Phone: ___________________ Cell Phone: ____________________ Work Phone: __________________

Preferred number to reach you? Home Cell Work OK to leave message at this number? Yes No

Patient Email Address: | | | | | | | | | | | | | | | | | | | | | | |

Primary Care Physician: _____________________________________ Phone: _________________________

Referring Physician: ____ Phone: _________________________

Date of Birth: ___________________ Gender: Male Female Marital Status: ___________________

Social Security #: ______________________ Employer/School: ____________________________________

Emergency Contact: _________________________ Relationship: _______________ Phone: ______________

Federal Privacy Standards require the following information:

Race: _____________________ Ethnicity:______________________ Primary Language: __________________
(i.e. Caucasian/Hispanic/Asian) (i.e. American/ Mexican/German)

Pharmacy: _____________________Cross streets: _________________________City: ___________________

How did you hear about us?

☐ Home ☐ Family Member ☐ Friend ☐ Internet ☐ Other: ________________

☐ Another Physician (Name of Physician):____

<u>Responsible Party/Insured Party Information</u>: (Please fill out completely **if other than self**)

Name: ____ Relationship: _________________________

Date of Birth: ___________________ SSN:___________________ Gender: Male Female

Address: _____________________________ City: __________________ State: ______ Zip: ____________

Home Phone #: ________________________ Cell #: __________________ Work #: ______________________

E-Mail: _____________________________ Responsible/Insured Party's Employer: _______________________

<u>Insurance Information</u>:

Primary Insurance: ____________________________ Secondary Insurance: ______________________________

Policy Holder: _______________________________ Policy Holder: ___________________________________

Policy ID#: ______________ Group #: __________ Policy ID#: __________________Group #: ____________

Date of Birth: _____________Gender: Male Female Date of Birth: _________________Gender: Male Female

Insurer's Address: ____________________________ Insurer's Address: _________________________________

If the primary policy holder is anyone other than you, please fill out Responsible Party/Insured Party Information above.

Signature: ____ Date: __________________

Referring Physician: ____

What is the reason for your visit today? ____

MEDICATIONS ☐ NONE

List all current prescription, non-prescription medications, vitamins, and herbal products. INCLUDE even occasional use of aspirin or anti-inflammatory medication.

Name	Name	Name
____________________	____________________	____________________
____________________	____________________	____________________

MEDICAL HISTORY (active & inactive) / Check all that apply: ☐ NONE

Do you have any heart issues? ☐ **Yes** ☐ **No**

Do you see a Cardiologist? ☐ **Yes** ☐ **No** **Name**______________ **Address**__________________ **Phone**________

-ENT-

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Chronic Ear Infections
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Nasal Polyps
- ☐ Nasal Allergies
- ☐ Recurrent Tonsillitis
- ☐ Ringing in Ears
- ☐ Vertigo

-**CANCER**-

- ☐ Thyroid
- ☐ Throat
- ☐ Other: ______________

-Heart -

- ☐ Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ Mitral Valve Prolapse
- ☐ Heart Valve Disease
- ☐ Atrial Fibrillation
- ☐ High Cholesterol
- ☐ High Blood Pressure

-**Lung-**

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis

-Other-

- ☐ Thyroid deficiency (hypothyroidism)
- ☐ Thyroid excess (hyperthyroidism)
- ☐ Diabetes Mellitus
- ☐ Anemia
- ☐ Hepatitis
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis/DJD
- ☐ Depression
- ☐ Anxiety

Other medical problems not listed above:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

ALLERGIES ☐ NONE

INCLUDE allergies to medications, foods and other medical products (examples: tape, latex, and iodine).
If allergic to food, do you carry an Epipen or Benadryl? ☐ Yes ☐ No

Name of Medicine, Food or Product:	Description of Reaction:
____________________	______________________________
____________________	______________________________
____________________	______________________________

SURGICAL HISTORY ☐ None

	Procedure	Month/Year
1.	______________________________	______________
2.	______________________________	______________
3.	______________________________	______________
4.	______________________________	______________

Patient Name: ______________________________ **DOB:**________________ **Date:** ____________

HOSPITALIZATION ☐ None

	Reason	Month/Year
1.	______________________________	____________________
2.	______________________________	____________________
3.	______________________________	____________________
4.	______________________________	____________________

FAMILY HISTORY					
	AGE	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

SOCIAL HISTORY

1) Do you now or have you ever smoked? ☐ NO ☐ YES If yes, how long?________ how often?______ year quit?__________

2) Risk factors for Hepatitis? (i.e. blood transfusions, intravenous drug abuse; report even remote or occasional drug use)

☐ NO ☐ YES If yes, explain: ______________________________

3) Do you consume caffeine? ☐ NO ☐ YES If yes, what kind? ______________________________

4) If patient is minor-child, are they in a daycare setting? ☐ NO ☐ YES

5) Do you have pets? ☐ NO ☐ YES If yes, what kind? ______________________________

6) Do you travel outside of U.S? ☐ NO ☐ YES If yes, when? __________________where?__________________

7) What is your occupation? ______________________________

Patient Name: ______________________________**DOB:** ______________________________

CONSENTS FORM

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Trinity ENT & Facial Aesthetics has the right to change its Notice of Privacy Practices from time to time and that I may contact Trinity ENT & Facial Aesthetics at any time to obtain a current copy.

**Signature: ____Date: ______________________

Authorization of Release of Health Information:

I hereby authorize Trinity ENT & Facial Aesthetics to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize Trinity ENT & Facial Aesthetics and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name:____________________________Relationship:______________________Phone: ____________________

Name:____________________________Relationship:______________________Phone: ____________________

Name:____________________________Relationship:______________________Phone: ____________________

**Signature: ____Date: ______________________

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

**Signature: ____Date: ______________________

Acceptance of In-Office Diagnostic Test/Procedures:

Patients presenting with sinus, allergy, throat, hearing or voice complaints may require diagnostic test/procedures such as, Audiogram (Hearing Test), Ear Wax Removal, Control of Nosebleed, Nasal Endoscopy, Sinus cleaning ("debridement") after sinus surgery, Laryngoscopy, Fiberoptic Endoscopic Evaluation of Swallowing (FEES), Minor in-office surgical procedures and/or biopsies. This list is not inclusive, but is representative of the most common tests.

These diagnostic test/procedures are separate charges from the physician's office consultation and may be applied to your deductible and/or coinsurance based on your insurance plan benefits.

By signing below you agree that you have read, understand, and agree to additional medically necessary diagnostic test/procedures and accept your specific financial responsibility based on insurance benefits.

**Signature: ____Date: ______________________

Patient Name: ____**DOB:** __________________________________