



ENT AND FACIAL AESTHETICS

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

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

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

Social Security #: _____ Employer/School: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Email Address: [Grid of 20 empty boxes]

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):

Responsible Party/Insured Party Information: (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: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____
Policy Holder: _____ Policy Holder: _____
Policy ID#: _____ Policy ID#: _____
Group #: _____ Group #: _____
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

-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 and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product:	Description of Reaction:
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY None

	<u>Procedure</u>	<u>Month/Year</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Patient Name: _____ **DOB:** _____ **Date:** _____

HOSPITALIZATION NoneReason

Month/Year

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY

AGE		HEALTH PROBLEMS		AGE		HEALTH PROBLEMS	
Father				Children	<input type="checkbox"/> M		
Mother					<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F						

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:** _____