ESENT EASTERN SHORE EAR, NOSE & THROAT CLINIC

Welcome to Our Office

Patient's Full Name: ______________________________________

Social Security #: ______________________________________

Date of Birth: _______________________ ☐ Male ☐ Female

REASON FOR VISIT: __________________________________

Street Address/Mailing: __________________________________

____

How did you hear about us? ☐ Internet ☐ Family/Friend ☐ Facebook ☐ Physician _______________ ☐ Other ___________

City, State, Zip: ____

Home Phone: ____

Cell Phone: ____

Emergency Contact Phone: ______________________________

Emergency Contact: ______________________________

Based on government regulations, we are required to ask the following:

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian

☐ Black or African American ☐ Caucasian ☐ I prefer not to answer

Preferred Pharmacy: ______________________________

Pharmacy Location: ______________________________________

Informed Consent to use Patient Portal

Eastern Shore Ear, Nose and Throat Clinic is offering this secure, HIPPA compliant communication tool as a courtesy to our patients and their parents. It is an optional service, and we reserve the right to suspend or terminate it at any time. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree to not hold Eastern Shore Ear, Nose and Throat Clinic or any of their staff liable for network infractions beyond their control.

☐ No, I do not consent to the Patient Portal

☐ Yes, I do consent to the Patient Portal

Email Address: ___________________________________ Signature- Patient/Guarantor____

Financial Responsibility ☐ Check if same as patient information. If not, please complete the entire section

Name: _________________________________ ☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Date of Birth: ____

Phone: ____

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office.

____ ____

Signature- Patient/Guarantor Date

Patient Authorization List

The following person(s) have permission to receive medical and/ or non-medical information relative to my treatment by EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C. This includes discussion with clinical personnel with regard to treatment provided to me by physicians of EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C., and test results ordered by physicians of EASTERN SHORE EAR, NOSE AND THROAT CLINIC, P.C., and/or discussion with clinic personnel with regard to financial matters relating to treatment received from EASTERN SHORE EAR, NOSE AND THROAT CLINIC,P.C.

Name: ____ Relationship: ______________________________ ☐ Medical ☐ Financial

Name: ____ Relationship: ______________________________ ☐ Medical ☐ Financial

Name: ____ Relationship: ______________________________ ☐ Medical ☐ Financial

____ ____

Signature- Patient/Guardian Date

Notice of Privacy Policy

I have reviewed the Notice of Privacy Practices as provided at registration and understand the I may request a copy of the policy at any time.

____ ____

Signature- Patient/Guardian Date

EASTERN SHORE EAR, NOSE & THROAT CLINIC, PC

NAME: ______________________ **DOB:** ____________ **PRIMARY M.D.** ____________

Which physician sent you to our office for this consultation?Have other members of your family been seen in this office? If so, name: ____________________

____

REASON FOR VISIT: ____________________

REVIEW OF SYSTEMS

Indicate below any symptoms <u>YOU ARE CURRENTLY HAVING:</u>

<u>Please Mark the NO Column if you do not have these symptoms.</u>

	Yes	No
1. Constitutional:		
A. Weight Loss	___	___
B. Fever	___	___
C. Fatigue	___	___
2. Ear, Nose, Throat:		
A. Ringing in Ear	___	___
B. Hearing Loss	___	___
C. Sinusitis	___	___
D. Hoarseness	___	___
E. Nosebleeds	___	___
3. Opthalmological:		
A. Loss of vision	___	___
B. Blurred vision	___	___
C. Double vision	___	___
4. Respiratior		
A. Cough	___	___
B. Shortness of Breath	___	___
C. Coughing blood	___	___
5. Cardiovascular		
A. Chest Pain	___	___
B. Irregular heartbeat	___	___
C. Light headedness	___	___
6. GI:		
A. Difficulty swallowing	___	___
B. Diarrhea	___	___
C. Nausea	___	___
7. Allergy:		
A. Hay fever	___	___
B. Wheezing	___	___
C. Swelling	___	___

	Yes	No
8. GU:		
A. UTI's	___	___
B. Difficulty urinating	___	___
9. Neurological		
A. Dizzy	___	___
B. Headache	___	___
C. Seizure	___	___
10. Musculoskeletal		
A. Muscle pain	___	___
B. Muscle weakness	___	___
11. Heme/Lymph:		
A. Easy bruising	___	___
B. Blood clots	___	___
C. Swelling(lymph node)	___	___
12. Endocrine		
A. Hot/cold intolerance	___	___
B. Night sweats	___	___
13. Skin		
A. Rash	___	___
B. Itching	___	___
C. Sores	___	___
14. Psych:		
A. Depression	___	___
B. Anxiety	___	___
C. Insomnia	___	___
D. Dementia	___	___

PHARMACY: ____________________ **LOCATION:** ____________________

Height: ______ **Weight:** ______ **Blood Pressure:** ______ **Pulse:** ______ **Temp.** ______

<u>PAST SURGICAL HISTORY:</u>

Have you had any problem with general anesthesia in the past? ___ **Yes** ___ **No**

List **ALL** previous surgeries with approximate dates**:** ____________________

____

____

____

NAME: ______________________________

INDICATE BELOW ANY HISTORY OF DISEASES YOU HAVE HAD:

	Yes	No		Yes	No
Arthritis	___	___	Hepatitis	___	___
Asthma	___	___	High Blood Pressure	___	___
Bleeding Tendency	___	___	High Cholesterol	___	___
Cancer: type: ________	___	___	Lung Disease	___	___
Diabetes	___	___	Reflux (Heartburn)	___	___
Glaucoma	___	___	Sleep Apnea	___	___
HIV/AIDS	___	___	Thyroid Disease	___	___
Heart Disease	___	___	Urinary Disease	___	___

List any other health conditions:

____

____

SOCIAL HISTORY:

Current or previous occupation: ______________________________

	Yes	No	
Are you pregnant?	___	___	
Alcohol Use?	___	___	Amount ____________ per week
Recreational Drug Use:	___	___	
Tobacco Use?	___	___	Year Quit _____ If smoking, ____ packs per day for_____ years

FAMILY HISTORY

Indicate below the diseases in YOUR PARENTS, BROTHERS OR SISTERS:

	Yes	No		Yes	No
Cancer: type:________	___	___	Hearing Loss	___	___
Heart Disease	___	___	Diabetes	___	___
High Blood Pressure	___	___	Bleeding Abnormalities	___	___
Lung Disease	___	___	Allergies	___	___

List any other health conditions: ______________________________

____

ALLERGIES TO MEDICATION: If none, check here: ___

Name:	Reaction	Name:	Reaction

CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION (include over-the-counter medications and any vitamins and herbal supplement):

NAME OF MEDICINE	DOSE/STRENGTH	HOW OFTEN
Example: Tylenol	325 mg	every 4-6 hours as needed