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

Home Phone: _____ ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Cell Phone: _____ ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian

Emergency Contact Phone: _____ ☐ Black or African American ☐ Caucasian ☐ I prefer not to answer

Emergency Contact: _____

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

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_____ _____

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:** _____ **Pediatrician:** _____

**Child's Nickname:** _____ **Parent's Name (s)** _____

**Have other members of your family been seen in this office? If so, name:** _____

**REASON FOR VISIT:** _____

## Review of Systems:

**Please Mark "Yes" or "No" if your child has recently had any of the following symptoms:**

| | Yes | No |
|---|---|---|
| **1. General Health Problems** | | |
| **A. Fever** | ___ | ___ |
| **B. Loss of appetite** | ___ | ___ |
| **2. Eye Problems** | | |
| **A. Eyes itching** | ___ | ___ |
| **B. Dark circle under eyes** | ___ | ___ |
| **3. Ear Problems** | | |
| **A. Ear pain** | ___ | ___ |
| **B. Ear drainage** | ___ | ___ |
| **C. Decreased hearing** | ___ | ___ |
| **4. Nose and Sinus Problems** | | |
| **A. Nasal congestion** | ___ | ___ |
| **B. Runny nose** | ___ | ___ |
| **C. Discolored drainage** | ___ | ___ |
| **D. Nosebleeds** | ___ | ___ |
| **5. Mouth & Throat Problems** | | |
| **A. Snoring** | ___ | ___ |
| **B. Sore throat** | ___ | ___ |
| **C. Sores in mouth** | ___ | ___ |
| **6. Respiratory Problems** | **Yes** | **No** |
| **A. Non-productive cough:** | ___ | ___ |
| **B. Productive cough:** | ___ | ___ |
| **C. Wheezing:** | ___ | ___ |
| **7. Stomach Problems** | | |
| **A. Diarrhea** | ___ | ___ |
| **B. Nausea/vomiting:** | ___ | ___ |
| **8. Nervous System Problems:** | | |
| **A. Seizures** | ___ | ___ |
| **B. Headaches** | ___ | ___ |
| **9. Problems with Glands/Hormones** | | |
| **A. Enlarged lymph nodes** | ___ | ___ |
| **B. Increased thirst** | ___ | ___ |
| **10. Allergy Problems:** | | |
| **A. Sneezing** | ___ | ___ |
| **B. Swelling of face, lips, tongue** | ___ | ___ |
| **C. Rash** | ___ | ___ |

**Has your child been diagnosed with any of the following: (Please circle)**

Acid Reflux Asthma Autism Cleft lip/ palate Diabetes Eczema Heart murmur Premature birth

Urinary tract infections Other: _____

**Has your child been diagnosed with any of the following: (Please circle)**

Ear Infections Nasal Allergies Recurrent Sinusitis Sleep Apnea Strep Throat Other: _____

**Has anyone in your family been diagnosed with any of the following: (Please circle)**

Cancer type: _____ Hearing loss at early age Nasal Allergies Asthma Heart Disease

Hypertension Other: _____

**SURGERIES AND HOSPITALIZATIONS:**

Has your child ever been hospitalized for a medical problem? ___ **Yes** ___ **No**

If yes, list hospitalizations, the reason for admission and the date**:** _____

_____

Has your child had any surgeries? ___ **Yes** ___ **No** If yes, list any surgeries and year done: _____

_____

**NAME:** _____

**SOCIAL HISTORY:**

Does your child use tobacco? ___ **Yes** ___ **No** If so, ___ packs/day for ___ years

Is there tobacco use in the household? ___ **Yes** ___ **No**

Is your child in day care? ___ **Yes** ___ **No**

Does your child consume alcohol? ___ **Yes** ___ **No** If so, how much? _____

**MEDICATION HISTORY:**

Pharmacy: _____ **Location:** _____

Is your child taking **ANY** kind of medication now? (This includes prescription or over-the-counter medications.)

___ **Yes** ___ **No** If yes, please list below and **include dosages:**

| **Medication Name:** | **Dosage** | **How often taken** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Is your child **ALLERGIC** to any medications? ___ **Yes** ___ **No** If yes, please list below:

| **Name of Medication** | **Type of Reaction** |
|---|---|
| | |
| | |
| | |

Weight _____ Height _____

Blood Pressure: _____ Pulse _____ Temperature _____

_____ _____ _____

Signature of Parent/Guardian