

PEAK ENT ASSOCIATES – PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

Patient Name \_\_\_\_\_
Last Name First Name M.I. Maiden

Gender - [ ] Male [ ] Female

Mailing Address \_\_\_\_\_
Street City State Zip

Marital Status \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Preferred Phone:

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Work Phone ( ) \_\_\_\_\_

[ ] Home

SSN# \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

[ ] Work

Preferred Language (if not English) \_\_\_\_\_

[ ] Cell

Email \_\_\_\_\_

Employer \_\_\_\_\_

Physician who sent you (First & Last Name) \_\_\_\_\_

Primary Care Physician (First & Last Name) \_\_\_\_\_

PARENT or RESPONSIBLE PARTY (if patient is under the age of 18 or under the guardian care of a third party)

Name \_\_\_\_\_
Last Name First Name M.I. Maiden

Gender - [ ] Male [ ] Female

Address \_\_\_\_\_
Street City State Zip

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone ( ) \_\_\_\_\_

SSN# \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Employment Status - [ ] Full-time or [ ] Part-time

Patient's Relationship to the Responsible Party \_\_\_\_\_

Other Parent's Name \_\_\_\_\_

INSURANCE INFORMATION (Despite our scanning your insurance card, please fill in all fields)

Primary Insurance:

Secondary Insurance:

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Address \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Subscriber's ID# \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_

Group# \_\_\_\_\_

Group# \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

EMERGENCY CONTACT (Not living with you)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

RELEASE OF MEDICAL INFORMATION - By signing below, I authorize the doctors and staff at Peak ENT and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostic tests, and lab results, to the below-named persons (e.g., spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 \_\_\_\_\_

Individual #2 \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES - I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. I understand co-payments are due at time of service. I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. I understand that some medical services performed in the office (audiology tests, CT scans, scopes, etc.) are billed separately from the office visit.

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

Patient or Patient's Representative Signature

Date

If signed by Representative, state name of: Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Date symptoms started: \_\_\_\_\_

Primary reason for visit: \_\_\_\_\_

*What symptoms are you having? (check all that apply)*

**Nose / Sinuses:**

- Facial pain
- Facial pressure
- Congestion
- Nasal discharge
- Postnasal drip
- Loss of smell
- Bleeding
- Headaches
- Fever
- Bad breath
- Tooth pain
- Fatigue

**Allergy:**

- Congestion
- Itchy eyes, nose, or throat
- Runny nose
- Sneezing

**Neck / Thyroid:**

- Swelling or lump
- Thyroid nodules
- Hypothyroidism
- Hyperthyroidism
- Parathyroid disorder

**Other:**

- Facial weakness/paralysis
- Cosmetic concerns

**Ears / Balance:**

- Hearing loss
- Pain
- Drainage
- Dizziness
- Ear infections
- Ringing
- Pressure or fullness

**Throat / Mouth:**

- Sores
- Pain
- Loose teeth
- Jaw pain
- Bad breath
- Trouble swallowing
- Voice changes
- Throat tightness
- Cough / throat clearing

**Tonsils / Adenoids:**

- Recurrent infections
- Persistent infection
- Recurrent white debris
- Snoring
- Mouth breathing
- Toss and turn / poor sleep

- Skin growths / skin cancer
- Other: \_\_\_\_\_

**MEDICAL HISTORY** *(check all that apply)*

- Heart problems
- Stroke
- Asthma or lung problem
- High blood pressure
- Diabetes
- Cancer *(list type)*

**LIST ALL DIAGNOSED MEDICAL CONDITIONS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIST ALL HOSPITALIZATIONS AND SURGERIES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIST CURRENT MEDICATIONS & SUPPLEMENTS:**

*(use back of this form for more space)*

| Name | Dose | Frequency | Route |
|------|------|-----------|-------|
|      |      |           |       |
|      |      |           |       |
|      |      |           |       |
|      |      |           |       |
|      |      |           |       |
|      |      |           |       |

**Preferred Pharmacy:** \_\_\_\_\_

*(Name, City)*

**LIST ALLERGIES TO MEDICATIONS:**

No Known Allergies

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY** *(check all that apply)*

- Alcohol use: \_\_\_\_ drinks per week       No Alcohol use
- At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)
- History of drug use
- Smoking Status:  Current    If current: \_\_\_\_ packs per day
- Former (when quit: \_\_\_\_\_)       Never smoked
- Second hand smoke exposure:
- Environmental     Occupational     Perinatal/before birth
- Tobacco use (other/chew): \_\_\_\_\_

**FAMILY HISTORY** *(check if blood relatives have the following)*

| DISEASE  | RELATIONSHIP TO YOU |
|--|---------------------|
| <input type="checkbox"/> Anesthesia problems           | _____               |
| <input type="checkbox"/> Bleeding tendency             | _____               |
| <input type="checkbox"/> Cancer                        | _____               |
| <input type="checkbox"/> Diabetes                      | _____               |
| <input type="checkbox"/> Heart disease                 | _____               |
| <input type="checkbox"/> Thyroid/Parathyroid disorders | _____               |

**PEDIATRIC PATIENTS ONLY** *(check all that apply)*

- Premature birth (< 38 weeks) or very low birth weight
- Infection or other problem during pregnancy or birth
- Immunizations are up-to-date
- Developmental delay (speech, walking, other)
- Lives with someone who smokes
- Attends day care

## REVIEW OF SYSTEMS

PLEASE CIRCLE 'YES' or 'NO' FOR ALL ITEMS BELOW  
(Problems you have had within the past 3 months)

### ALLERGY/IMMUNE

Yes No Hayfever  
Yes No Swollen glands or nodes  
Yes No Weak immune system

### CARDIOVASCULAR

Yes No Chest pain  
Yes No High blood pressure  
Yes No Palpitation or heart racing  
Yes No Swelling in legs or feet

### EARS

Yes No Ear aches  
Yes No Ear infections  
Yes No Hearing problems  
Yes No Tinnitus  
Yes No Vertigo

### ENDOCRINE

Yes No Breast discharge  
Yes No Diabetes  
Yes No Excessive thirst  
Yes No Heat or cold intolerance  
Yes No Thyroid problems

### EYES

Yes No Blurry vision  
Yes No Double vision  
Yes No Glasses or contacts  
Yes No Glaucoma

### GENERAL

Yes No Fatigue  
Yes No Fever  
Yes No Loss of appetite  
Yes No Night sweats  
Yes No Recent weight change

### GASTROINTESTINAL

Yes No Abdominal pain  
Yes No Blood in stool  
Yes No Constipation  
Yes No Diarrhea  
Yes No Difficulty swallowing  
Yes No Heartburn  
Yes No Nausea or vomiting

### GENITOURINARY

Yes No Blood in urine  
Yes No Frequent urination  
Yes No Kidney stones  
Yes No Loss of bladder control

### HEMATOLOGIC/LYMPH

Yes No Anemia  
Yes No Blood transfusions  
Yes No Easy bruising or bleeding

### INTEGUMENTARY (Skin)

Yes No Changes in hair or nails  
Yes No Dryness  
Yes No New stretch marks  
Yes No Rashes

### MOUTH and THROAT

Yes No Dry mouth  
Yes No Frequent sore throats  
Yes No Sore tongue

### MUSCULOSKELETAL

Yes No Back pain  
Yes No Muscle cramps  
Yes No Muscle weakness  
Yes No Neck pain  
Yes No Swelling or pain in joints

### NEUROLOGIC

Yes No Frequent headaches  
Yes No Head injury  
Yes No Loss of consciousness  
Yes No Numbness around mouth  
Yes No Numbness or tingling  
Yes No Seizures  
Yes No Tremors

### NOSE and SINUSES

Yes No Frequent colds  
Yes No Nasal stuffiness  
Yes No Sinus troubles

### PSYCHIATRIC

Yes No Anxiety  
Yes No Depression

### RESPIRATORY

Yes No Asthma  
Yes No Frequent cough  
Yes No Shortness of breath  
Yes No Spitting up blood  
Yes No Wheezing

I have reviewed the above and circled all symptoms which apply.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_