**Name**: _____

**Date of Birth**:_____**Age**: _____

**Primary Care Doctor (Name and Location)**:_____

**Who referred you to our office?** :_____

**Reason for visit**: _____

**Do you have an Audiologist?** [ ] Yes [ ] No If yes who?_____Date of last visit? _____

**Do you have any of the following health problems:** [ ] I have none of the below

| | | | |
|---|---|---|---|
| [ ] Asthma | [ ] Diabetes | [ ] High Cholesterol | [ ] Heart Disease |
| [ ] Thyroid Disorder | [ ] HIV/AIDS | [ ] High blood pressure | [ ] Sleep apnea |
| [ ] Headache | [ ] Hepatitis C | [ ] Liver or Kidney disease | [ ] Seizure disorder |
| [ ] Cancer type:_____ | | | [ ] Reflux/GERD |

**Please list other health issues**: _____

_____

**For Women: Is there a possibility you are pregnant?** Yes [ ] No [ ]

**Have you had any of the following surgeries?** [ ] I have never had Surgery

| | | | |
|---|---|---|---|
| [ ] Septoplasty | [ ] Ear Tubes | [ ] Thyroidectomy | [ ] Cosmetic Surgery |
| [ ] Sinus Surgery | [ ] Tonsillectomy | [ ] Other Head and Neck Surgery | |
| [ ] Ear Surgery | [ ] Adenoidectomy | [ ] Dental Surgery | |

**Please list other surgeries**: _____

_____

**Family Medical History:** *Indicate which family member beside each condition: (M) mother (F) father (C) child (B) brother(S) sister Example: (M) allergies*

| | | | |
|---|---|---|---|
| ____Allergies | _____Bleeding Disorder | _____Migraine | _____Cancer type: _____ |
| ____Diabetes | _____Heart Disease | _____Thyroid Disorder | [ ] Unknown/Adoption |
| ____Hearing Loss | _____Stroke | _____Asthma | |

Mother: [ ] Alive [ ] Deceased Cause of Death_____ Age:_____

Father: [ ] Alive [ ] Deceased Cause of Death_____ Age:_____

(**Please turn over)**

**Social History: (age 13 and above)**

**Do you currently use tobacco products?** [ ] Yes [ ] No If yes what type? _____

How much a day?_____For how many years? _____

**Have you previously used tobacco products?** [ ] Yes [ ] No If so what type? _____

When did you quit?_____For how many years? _____

**Do you use recreational drugs?** [ ] Yes [ ] No If yes what type? _____

**Do you drink alcohol?** [ ] Yes [ ] No If yes how much per week? _____

**Do you drink caffeinated beverages?** [ ] Yes [ ] No If yes what type?_____Weekly amount? _____

**Have you had chemical exposure?** [ ] Yes [ ] No

**Have you had or do you have excessive noise exposure?** [ ] Yes [ ] No

If yes, what type? _____

**Do you have any pets in the home?** [ ] Yes [ ] No

If yes what type?_____

**Current occupation?** _____

**Have you had a Flu Vaccine?** Yes [ ] No [ ] **Have you had a Pneumonia Vaccine?** Yes [ ] No [ ]

**Date:**_____ **Date:**_____

REVIEW OF SYSTEMS: Do you have any of the following symptoms:

| | | | | |
|---|---|---|---|---|
| Constitutional: | ☐fever | ☐weight loss | ☐fatigue | ☐daytime sleepiness |
| Eye: | ☐vision loss | ☐double vision | ☐floaters | ☐flashes of light |
| Ear, Nose, Mouth, Throat: | ☐hearing loss | ☐snoring | ☐nasal bleeding | |
| Cardiovascular: | ☐chest pain | ☐palpitations | ☐passing out | ☐shortness of breath |
| Pulmonary: | ☐dry cough | ☐productive cough | ☐wheezing | ☐coughing up blood |
| Gastrointestinal: | ☐heartburn | ☐constipation | ☐diarrhea | ☐trouble swallowing |
| Genitourinary: | ☐blood in urine | ☐weak urine flow | | ☐painful urination |
| Musculoskeletal: | ☐joint pain | ☐joint swelling | ☐muscle aches | ☐swollen feet |
| Integumentary/skin: | ☐rash | ☐itchy ears | ☐non-healing wound | |
| Neurologic: | ☐dizziness | ☐weakness | ☐headache | ☐memory loss |
| Psychiatric: | ☐depression | ☐anxiety | ☐claustrophobia | ☐panic attacks |
| Endocrine: | ☐heat intolerance | ☐cold intolerance | ☐frequent urination | |
| Hematologic/lymphatic: | ☐easy bruising | ☐swollen glands | ☐bleeding | |
| Allergy/immunologic: | ☐spring allergies | ☐fall allergies | ☐summer allergies | ☐winter allergies. |

I certify that to the best of my knowledge, the above information is complete and accurate.

**Patient** or guardian's signature:_____Date: _____

Reviewing physician's signature:_____Date: _____

CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

**Name: _____ Date of Birth: _____**

**Local Pharmacy Name: _____ Town: _____**

**Mail Away Pharmacy: _____**

**Do you have any known drug allergies? [ ] Yes [ ] No**

Please list any drug allergies along with reaction: _____

_____

_____

**Are you allergic to LATEX, adhesive tape or rubber? [ ] Yes [ ] No**

## Medication List

(***Please list all medications, including vitamins, OTC medications and prescription marijuana)***

| NAME OF MEDICATION | DOSAGE | WHAT IS IT TAKEN FOR? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***Please sign below to give permission to retrieve your prescription history.***

**Sign Name:_____Date: _____**

# CAPE COD EAR, NOSE AND THROAT SPECIALISTS
# HEAD & NECK SURGERY, P.C.

***Welcome to our Office!***

*Please complete both sides and present your insurance card and photo ID to reception.*

**Patient Information:**

Last Name:_____ First Name:_____ MI:____

Date of Birth:_____ Age:_____ M/F:_____

Mailing Address: _____

City/State/Zip:_____

Phone:_____ Cell: _____

Email:_____ Social Security #: _____

Primary Care Physician/Pediatrician: _____

Employer: _____

Did you make an appointment with us because of a Motor Vehicle Accident? Y / N

Or Work Related Injury? Y / N

Race: American Indian or Alaska Native ( ) White ( ) Asian ( )

Black or African American ( ) Native Hawaiian/Pacific Islander ( )

Hispanic ( ) Other ( )

Ethnicity: Hispanic or Latino ( ) Not Hispanic or Latino ( )

**Insurance Information:**

Primary Insurance: _____

Insured's Name: _____

Patient's Relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Holder's Birthdate:_____ S.S. #: _____

Secondary Insurance: _____

**If patient is under 18 years of age:**

Parent/Guardian Name:_____ S.S. #: _____

Address:_____ DOB: _____

(please turn over)

1. **FINANCIAL AGREEMENT**

I understand that I am financially responsible for charges for services rendered. This includes the balance after insurance has paid or denied, including deductibles, copays and co-insurance.

2. **ASSIGNED BENEFITS**

I request that payment of authorized medical benefits be made on my behalf directly to CCENT for services rendered. I authorize any holder of medical information regarding me be released to my insurance company of health plan and its agents and any information needed to determine these benefits payable for related services. If claims are to be submitted to the insurance carrier for my visits, complete information is required along with any referrals required by my insurance carrier. If I am unable to provide this information, payment will be expected at time of visit for services rendered. An office copay is due at the time of the visit. Any procedure performed in office may be considered by my insurance carrier as surgery and may have a separate deductible.
This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid and original.
I have read this information and understand it.

**Signature of Patient or Patient Representative:**

***_____Date: _____**

If Patient Representative, please print name: _____

3. **VOICE MAIL RELEASE**

I give permission to have test results or responses to my inquiries etc. be left as a voice mail on my provided phone numbers.

**Signature of Patient or Patient Representative:**

***_____Date: _____**

4. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

The undersigned acknowledges receipt of the Notices of Privacy Practices of Cape Cod Ear, Nose and Throat Specialist and/or the opportunity to review the Notice of Privacy Practices and retain a copy.

**Signature of Patient or Patient Representative:**

***_____Date: _____**

5. **RELEASE OF INFORMATION**

Please list all non-medical persons that we may speak to regarding you or your child's medical care.

1._____

2. _____

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The Patient or the Patients Legal Representative did not provide a written acknowledgement of receipt of the Notice of Privacy Practice's. The following explains the good faith efforts to obtain the written acknowledgments and reason why the acknowledgement was not obtained:

_____

_____