Desoto Ear, Nose, and Throat

Patient Name:	**Date of Birth:**
Height:	**Weight:**
What Is Your Current Occupation?	
Who Referred You?	
Reason For Today's Visit:	

Have you ever been diagnosed with any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Alcoholism	☐	☐	Diabetes	☐	☐	Polio	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Sickle Cell Disease	☐	☐
Anxiety	☐	☐	Heart Disease	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐	Stomach Ulcers	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Bleeding Tendencies	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Cancer: Type:_____	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Colitis	☐	☐	Lung Disease	☐	☐			
Depression	☐	☐	Lupus	☐	☐			
Developmental Condition	☐	☐	Nervous System Problems	☐	☐			

List Other Medical Conditions? _____

Please List All Current Medications and Dosages: None ☐

Please List Any Drug, Latex, or Food Allergies You Have: None ☐

Have You Ever Had Any Surgery? No ☐ **Yes** ☐ **(Please list ALL below)**

Procedure	Date	Complications

Do You Currently Use Tobacco or Drugs? Yes☐ No☐ **Have You Used Them In The Past? Yes**☐ **No**☐

Cigarettes: Yes☐ E-Cigarette: Yes☐ Pipe: Yes☐ Smokeless: Yes☐ Recreational: Yes☐ (**Check all that apply**)

How Much?	How Long?	Quit Date?

Do You Drink Alcohol? Yes☐ No☐

Beer: Yes☐ Wine: Yes☐ Liquor: Yes☐ **(Check all that apply)**

How Much?	How Long?

Has Anyone In Your Family Had: (Check all that apply)

None ☐	Unknown ☐	Bleeding Problems ☐	Cancer ☐ **Type:**
Diabetes ☐	Heart Disease ☐	Hypertension ☐	Lung Disease ☐

*** Have You Recently Had Any Of The Following Problems or Symptoms?**

	Yes	No		Yes	No
Chest Pain	☐	☐	Fever or Chills	☐	☐
Breathing Difficulty	☐	☐	Abdominal Pain	☐	☐
Irregular Heartbeat	☐	☐	Bloody/Tarry Stool	☐	☐
Cough	☐	☐	Diarrhea	☐	☐
Cough With Blood	☐	☐	Loss of Bowel Control	☐	☐
Fainting Spells	☐	☐	Loss of Bladder Control	☐	☐
Dizziness	☐	☐	Pain/Burning Urination	☐	☐
Numbness/Tingling	☐	☐	Blood in Urine	☐	☐
Vision Changes	☐	☐	Difficulty Starting Urination	☐	☐
Headaches or Migraines	☐	☐	Unexpected Weight Loss	☐	☐
Nausea/Vomiting	☐	☐			

Have you had a colonoscopy in the last 10 years? _____When? (MM/YEAR) _____

Have you had a Pap Smear in the 5 years? _____When? (MM/YEAR) _____

Have you had a mammogram in the last 3 years? _____ When? (MM/YEAR) _____

The above information is accurate to the best of my knowledge. Please sign below.

_____ _____

Signature of patient or guardian **Date of Signature**

I have reviewed the information with the patient.

Physician Signature	Date

WELCOME TO OUR OFFICE

Child Form

We pride ourselves in the efficiency of our office. If you provide all of the information below, we are able to serve you better with your medical care and in filing of your insurance. Please do not leave anything blank. Thank you!

Patient Name:	First:	M:	Last
Patient:	D.O.B:	Age:	Sex:	SSN:
Address of Patient:			
City:	State:	Zip:	
Telephone:			

LEGAL GUARDIAN INFORMATION:

(If under 18 years of age)

Mother:

Name:	D.O.B:	Are you a legal guardian? ☐ Yes ☐ No
Employer Name:	Occupation:	
Home #:	Work:	SSN:
Cell #:	Email Address:	

Father:

Name:	D.O.B:	Are you a legal guardian? ☐ Yes ☐ No
Employer Name:	Occupation:	
Home #:	Work:	SSN:
Cell #:	Email Address:	

INSURANCE INFORMATION

Company Name:		
Claims Address:		
Phone #:	ID #:	Group #:
Insured's Name:	Employer:	
Social Security #:	Date of Birth:	

SECONDARY INSURANCE: (If Any)

Company Name:		
Claims Address:		
Phone #:	ID #:	Group #:
Insured's Name:	Employer:	
Social Security #:	Date of Birth:	

In Case of an Emergency, Contact: (Other than self, spouse, or guardian)

Name:	Relationship:
Home Phone:	Mobile Phone:

**Do you wish to give someone your permission to bring your child to be seen?

If you pick yes, please list their name(s):_____

Who is your Primary Care Dr/Pediatrician?	Phone #:
Preferred Pharmacy Name:	Phone #:
How did you learn about Desoto ENT?	
May we leave you a message regarding appointments or test results?	

The above information is accurate to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical and surgical benefits to: *Desoto Ear Nose and Throat.* I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility. I understand that I will be responsible for any attorney fees or cost of collections if required to obtain payment. I have read, understand, and agree to this Financial Policy.

Signed _____ ***Date:*** _____

ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of Desoto Ear Nose and Throat's Notice of Privacy Practices.

Signature: _____

AUTHORIZATION TO DISCLOSE INFORMATION

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I hereby authorize Desoto Ear Nose and Throat to disclose information regarding my treatment, insurance issues and payment issues to the people listed below. These individuals will be asked to identify themselves and state the patient's birth date.

Name (please print)	Relationship (please print)

I understand that this authorization is voluntary. I understand that the person to whom I Authorize disclosure of my personal data is not a health plan, health care provider or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulation. I understand that I may withdraw my authorization in writing to the privacy Officer of Desoto Ear Nose and Throat at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire 1 year from this date. I have carefully read and understand the above and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

Signature of patient or patient's representative_____

Printed name of patient's representative_____

Relationship to the patient_____