SOUTH VALLEY ENT ASSOCIATES – PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

Patient Name _____ Gender - ☐ Male ☐ Female
Last Name First Name M.I Maiden

Mailing Address _____ Marital Status _____
Street City State Zip

Home Phone (_____)_____ Preferred Phone:
Work Phone (_____)_____ ☐ Home
Cell Phone (_____)_____ ☐ Work
☐ Cell

Date of Birth _____ / _____ / _____

SSN# _____

Email _____

Employer _____

*In accordance with federal guidelines, please indicate the following:

Preferred Language (if not English) _____

Ethnicity - ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race - ☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other Race

Physician who sent you (First & Last Name) _____

Primary Care Physician (First & Last Name) _____

Preferred Pharmacy _____

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

Name _____ Phone _____

Relation to Patient _____

PARENTS OF PATIENT

Father's Name _____ Mother's Name_____
Home Address _____ Home Address _____
Phone _____ DOB ___/___/____ Phone _____ DOB ___/___/____
Employer _____ Employer _____

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

Primary Insurance:
Insurance Company _____
Subscriber's Name _____
Subscriber's Date of Birth _____ / _____ / _____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

Secondary Insurance:
Insurance Company _____
Subscriber's Name _____
Subscriber's Date of Birth _____ / _____ / _____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

EMERGENCY CONTACT (Not living with you)

Name _____ Relationship _____ Phone (_____)_____
Address _____

RELEASE OF MEDICAL INFORMATON – By signing below, I authorize the doctors and staff at South Valley ENT 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. A $25 charge will be applied to all returned checks. **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 _____

SOUTH VALLEY EAR NOSE & THROAT
PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____ DOB: _____ DATE: _____

REASON FOR VISIT:

_____

_____

MEDICAL HISTORY

Do you have any allergies to medications? □ Yes □ No
Do you have any allergies to foods? □ Yes □ No
If yes, list allergies and reactions:

_____

_____

Have you been exposed to loud noises (work or hobbies)? □ Yes □ No If yes, explain: _____
Have you suffered a head injury? □ Yes □ No If yes, explain: _____
Have you taken medication known to damage ears? □ Yes □ No □ Unsure
Have you ever had IV antibiotic treatment for infection? □ Yes □ No
List travel outside the US in the last year: _____

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS:

Medication	Dose	Frequency

LIST ALL HOSPITALIZATIONS AND SURGERIES:

_____

_____

SOCIAL HISTORY: CHECK ALL THAT APPLY

Do you drink alcohol? □ Yes □ No If yes, how many drinks per week? _____
At risk for HIV infection? (Unprotected sex, IV drug use, blood transfusions) □ Yes □ No
History of drug use? □ Yes □ No
Smoking Status: □ Never smoker
□ Current every day smoker; packs per day_____
□ Current some day smoker
□ Former smoker
□ Members in household smoke
Other tobacco use: □ Yes □ No If yes, please specify: _____

FAMILY HISTORY: CHECK ALL THAT APPLY TO BLOOD RELATIVES Adopted? □ Yes □ No

	RELATIONSHIP TO YOU		RELATIONSHIP TO YOU
□ Allergy	_____	□ Anesthesia Reaction	_____
□ Asthma	_____	□ Bleeding Tendency	_____
□ Cancer	_____	□ Diabetes	_____
□ Hearing Loss	_____	□ Heart Disease	_____
□ High Blood Pressure	_____	□ Other	_____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Bleeding/Clotting Problems
- ☐ Diabetes
- ☐ Heart Disease/Disorder
- ☐ Kidney Disease/Disorder
- ☐ Pneumonia
- ☐ Skin Disease/Disorder
- ☐ Thyroid Disease/Disorder
- ☐ Anemia
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Liver Disease/Disorder
- ☐ RSV
- ☐ Sleep Apnea
- ☐ Ulcers
- ☐ Anesthesia Reaction: _____
- ☐ Autoimmune Disorder: _____
- ☐ Cancer: _____
- ☐ Hay Fever/Seasonal Allergies
- ☐ HIV/AIDS Infection
- ☐ Nasal/Sinus Polyps
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

REVIEW OF SYSTEMS: CHECK ALL CURRENT OR RECENT SYMPTOMS

CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

EARS,NOSE & THROAT

- ☐ Headaches
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Pressure
- ☐ Ear Discharge
- ☐ Ear Fullness/Pressure
- ☐ Ear Pain (tugging at ears)
- ☐ Ear Swelling
- ☐ Hearing Loss
- ☐ Itching in Ear
- ☐ Ringing in Ears
- ☐ Enlarged Tonsils
- ☐ Snoring
- ☐ Sore Throat
- ☐ Change in Voice
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Lump in Throat Sensation
- ☐ Neck Mass
- ☐ Swollen Glands
- ☐ Thyroid Nodule

EYES

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision Loss

CARDIOVASCULAR

- ☐ Irregular Heart Beat
- ☐ Pain in Chest
- ☐ Swelling of Feet or Ankles

RESPIRATORY

- ☐ Cough
- ☐ Coughing up phlegm
- ☐ Difficulty Breathing

GASTROINSTESTINAL

- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting

MUSCULOSKELETAL

- ☐ Joint Pain
- ☐ Muscle Pain

ENDOCRINE

- ☐ Heat Intolerance
- ☐ Cold Intolerance

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping

HEMATOLOGIC/LYMPHATIC

- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes

SKIN

- ☐ Rash
- ☐ Itching

NEUROLOGIC

- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Muscular Weakness
- ☐ Numbness/Tingling
- ☐ Vertigo

REPRODUCTIVE

- ☐ Breastfeeding
- ☐ Pregnant
- ☐ Trying to Conceive

OTHER

- ☐ _____
- ☐ _____