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 _____

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ Date: _____

Reason for Visit: _____

_____

_____

MEDICAL HISTORY

Do you have any of the following? □ Hay Fever □ Asthma □ Eczema □ Food Allergies

Have you ever undergone allergy testing? □ Yes □ No

List allergies to medications: _____

_____

Have you been exposed to loud noises (work or hobbies)? □ Yes □ No

Have you taken medication known to damage ears? □ Yes □ No □ Unsure

Have you suffered a head injury? □ Yes □ No *describe*: _____

Have you ever had IV antibiotic treatment for infection? □ Yes □ No □ Unsure

List travel outside the US in the last year: _____

List current medications and supplements:

Name	Dose	Fequency

List all hospitalizations and surgeries: _____

_____

_____

SOCIAL HISTORY (check all that apply)

□ Alcohol use:_____ drinks per week □ Never

□ At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)

□ History of drug use

Smoking Status: □ Never smoker

□ Current every day smoker ___ packs per day

□ Current some day smoker

□ Former smoker

□ Members in household smoke

□ Tobacco use (other): _____

FAMILY HISTORY (check if blood relatives have the following)

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

PAST MEDICAL HISTORY (check all that apply)

- ☐ Acid Reflux
- ☐ Asthma
- ☐ COPD
- ☐ Glaucoma
- ☐ Heart Disorder
- ☐ Liver Disease
- ☐ Seizure
- ☐ Thyroid Problem
- ☐ Pneumonia
- ☐ Autoimmune Disorder
- ☐ Arthritis
- ☐ Stroke
- ☐ Free Bleeding/Clotting
- ☐ High Blood Pressure
- ☐ Skin Disorders
- ☐ Ulcers
- ☐ Anemia
- ☐ Cancer _____
- ☐ Nasal Polyps
- ☐ HIV
- ☐ RSV
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Anesthesia Reaction
- ☐ Multiple Sclerosis
- ☐ Kidney Disorder
- ☐ Other _____

REVIEW OF SYSTEMS (check any current or recent problems)

CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain

EARS,NOSE & THROAT

- ☐ Dizziness
- ☐ Sinus Pain
- ☐ Headaches
- ☐ Nasal Obstruction
- ☐ Nasal Congestion
- ☐ Nose Bleeding
- ☐ Postnasal Drip
- ☐ Thyroid Mass
- ☐ Sore Throat
- ☐ Ear Pain (Tugging at ears)
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ear Discharge
- ☐ Ear Fullness
- ☐ Itching in Ear
- ☐ Ear Swelling
- ☐ Decreased Sense of Smell
- ☐ Snoring
- ☐ Enlarged Tonsils
- ☐ Lump in Throat Sensation
- ☐ Hoarseness
- ☐ Change in Voice
- ☐ Difficulty Swallowing
- ☐ Neck Mass
- ☐ Swollen Glands

EYES

- ☐ Blurred Vision
- ☐ Double Vision

CARDIOVASCULAR

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

RESPIRATORY

- ☐ Cough
- ☐ Coughing up Phlegm
- ☐ Difficulty Breathing

GASTROINSTESTINAL

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn

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

- ☐ Loss of Balance
- ☐ Numbness
- ☐ Muscular Weakness

OTHER

- ☐ Trying to Conceive
- ☐ Pregnant
- ☐ Breastfeeding

I have reviewed the above and checked all symptoms that apply.

Print Name:_____

Date of Birth:_____

Today's Date:_____