NEW PATIENT INTAKE FORM

Patient's Last Name _____ First Name_____ Middle Initial _____

Date of Birth _____ Age _____ Sex: F M SSN _____

Address _____ Apt.#_____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Business Phone _____ E-mail Address _____

Employer _____ Employer Address _____

Medical Doctor Name _____ Medical Doctor Telephone _____

Medical Doctor Fax_____ Medical Doctor Address _____

Language _____ Race _____ Ethnicity _____

Emergency Contact _____ Phone # _____

PRIMARY MEDICAL INSURANCE

Insurance _____ Patient's ID # _____

Group Name (if applicable) _____ Group # (if applicable) _____

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

SECONDAY MEDICAL INSURANCE

Insurance _____ Policy Holder ID # _____ Patient's ID # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

OTHER COVERAGE

Is this visit covered by Workers' Comp? _____ No Fault? _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

I have received Ear, Nose & Throat Associates of New York, P.C. notice of privacy practice.

Responsible Party Signature: _____ Date: _____

WHAT IS THE MAIN REASON YOU ARE HERE TODAY? Ear _____

Nose _____ Throat _____

PHARMACY INFORMATION (Include Address &/or Phone**)**

_____

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Ear, Nose & Throat Associates of New York, P.C. to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal): ☐ **No Current Medications**

List of Medication(s)	Dosage	List of Medication(s)	Dosage	List of Medication(s)	Dosage
1._____	_____	4._____	_____	7._____	_____
2._____	_____	5._____	_____	8._____	_____
3._____	_____	6._____	_____	9._____	_____

ALLERGIES TO MEDICATIONS: ☐ **No Allergies to Medications**

_____

SMOKING STATUS & SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No ☐ Former Amount per day? _____ Quit Date? _____
Exposed to second hand smoke? ☐ Yes ☐ No

Alcohol Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____
Caffeine Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____

FAMILY HISTORY: ☐ **No Family History**

ADD/ADHD	☐	Depression	☐	Migraines	☐
Alcoholism	☐	Developmental Delay	☐	Obesity	☐
Allergies	☐	Diabetes	☐	Osteoarthritis	☐
Alzheimer's Disease	☐	Eczema	☐	Osteoporosis	☐
Asthma	☐	Hearing Deficiency	☐	Seizure Disorder	☐
Blood Disease	☐	Hypertension	☐	Thyroid Disease	☐
CAD (Coronary Artery Disease)	☐	Irritable Bowel Syndrome	☐	Vascular Disease	☐
Cancer Type: _____	☐	Kidney Disease	☐	Other:_____	
CVA (Stroke)	☐	Mental Illness	☐		

MEDICAL HISTORY: Have you ever been DIAGNOSED with any of the following? ☐ **No Medical History**

Adjustment Disorder - Anxiety	☐	Gastroesophageal Reflux	☐	Prostate Enlargement	☐
Anemia	☐	Glaucoma	☐	Recurrent Tonsillitis	☐
Asthma	☐	Hearing Loss	☐	Renal Failure (Acute)	☐
Bronchitis	☐	Hepatitis	☐	Sinus Problems (Chronic Sinusitis)	☐
Cancer Type: _____	☐	Hernia	☐	Sleep Apnea	☐
Cataracts	☐	High Blood Pressure (Hypertension)	☐	Thyroid Deficiency (Hypothyroidism)	☐
Chronic Ear Infections (Otitis Media)	☐	Kidney Stones (Nephrolithiasis)	☐	Thyroid Excess (Hyperthyroidism)	☐
COPD	☐	Major Depression	☐	Tinnitus	☐
CAD (Coronary Artery Disease)	☐	Migraine	☐	Tuberculosis	☐
Diabetes Type: _____	☐	Mononucleosis	☐	Vertigo	☐
Elevated Cholesterol (Hyperlipidemia)	☐	Nasal Allergies	☐		
Emphysema	☐	Nasal Polyps	☐	Other: _____	

Patient Name: _____ DOB:_____

Responsible Party Signature: _____ Date: _____

SURGICAL HISTORY: Have you ever had any of the following surgeries? ☐ No Surgical History

ENT Surgery ☐ If yes, please list type of surgery:

Ear _____

Nose_____

Throat_____

Abdominal Surgery	☐	Liver Surgery	☐
Brain Surgery	☐	Lung Surgery	☐
Arm or Leg Surgery	☐	Mid/Lower Back Surgery	☐
Head/Facial Surgery	☐	Neck Surgery	☐
Heart Surgery	☐	Stomach Surgery	☐
Kidney Surgery	☐		

GENERAL ALLERGIES: ☐ No Allergies

Do you have any food allergies?	☐ Yes	☐ No	If yes, type:_____
Do you have any allergies?	☐ Yes	☐ No	If yes, type:_____
Have you ever had an allergy test?	☐ Yes	☐ No	
Have you ever taken allergy shots?	☐ Yes	☐ No	
If yes, are you still taking them?	☐ Yes	☐ No	How much relief from shots? ☐ minimal ☐ partial ☐ significant

REVIEW OF SYSTEMS: Please mark where applicable

Blood or Lymph nodes problems

Yes	No	
☐	☐	Easy Bleeding
☐	☐	Easy Bruising

Brain or Nervous system problems

Yes	No	
☐	☐	Focal Weakness
☐	☐	Headache
☐	☐	Numbness
☐	☐	Seizures

Ear problems

Yes	No	
☐	☐	Dizziness
☐	☐	Drainage
☐	☐	Ear pain
☐	☐	Exposure to Excessive Noise
☐	☐	Hearing loss
☐	☐	Infections
☐	☐	Itchiness
☐	☐	Ringing /Noise in Ears

Eye problems

Yes	No	
☐	☐	Double Vision
☐	☐	Itchy Eyes
☐	☐	Redness

General health problems

Yes	No	
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Weight Loss
☐	☐	Weight Gain

Glands & Hormone problems

Yes	No	
☐	☐	Cold Intolerance
☐	☐	Heat Intolerance
☐	☐	Neck Enlargement/Goiter

Heart or circulation problems

Yes	No	
☐	☐	Blacking Out
☐	☐	Chest Pain
☐	☐	Heart Murmur
☐	☐	Irregular Heartbeat/Palpitations
☐	☐	Swelling of Ankles/Edema

Lung or respiratory problems

Yes	No	
☐	☐	Cough
☐	☐	Shortness of Breath
☐	☐	Wheezing

Mouth & Throat problems

Yes	No	
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Sore Throat
☐	☐	Sores/Ulcers in Mouth

Musculoskeletal:

Yes	No	
☐	☐	Leg pain

Nose & Sinus problems

Yes	No	
☐	☐	Congestion
☐	☐	Facial Pain
☐	☐	Mouth Breathing
☐	☐	Nose Bleeds
☐	☐	Post Nasal Drainage
☐	☐	Runny Nose
☐	☐	Sneezing

Skin

Yes	No	
☐	☐	Contact Allergy
☐	☐	Itchy Skin/ Pruritus
☐	☐	Rash

Stomach problems

Yes	No	
☐	☐	Abdominal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting/Goiter

Patient Name: _____ **DOB:_____**

Responsible Party Signature: _____ **Date: _____**