LAKE COUNTY HEAD & NECK SPECIALISTS, S.C.

EAR, NOSE & THROAT SPECIALISTS

Family/Referring Physician:	Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:	Cell phone no.: ( )

Employer:	Occupation:	Employer phone no.: ( )

Business Address:	City:	State:	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)
(There is no need to fill out policy and group number if card is presented.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I hereby authorize Lake County Head & Neck Specialists, S.C. to furnish to the above insurance company(s) all information which said insurance company(s) may request. I hereby assign to Lake County Head & Neck Specialists, S.C. all money to which I am entitled for medical and/or surgical expense relative to the service rendered, but not to exceed my indebtedness to said physician and/or surgeon. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required. In the event the bill is not paid and is turned over to our professional collection company, information will be given to them and may include, but is not limited to: name, address, phone number, social security number, employment and employment phone number.

_____ _____

Patient/Guardian signature *Date*

Lake County ENT/Head and Neck Specialists: New Patient
CONFIDENTIAL HEALTH HISTORY

Name: _____ Date: _____

Date of Birth: _____

Did another physician refer you to us? Yes/No

If yes, who? _____

If no, how did you find our office? _____

CHIEF COMPLAINT

1. Please explain why you are here (explain the most troubling symptom):
_____
_____

2. When did the problem start?
_____
_____

3. Where were you, or what were you doing, when the problem started?
_____
_____

4. Does the pain/problem occur at a specific time of day?
_____
_____

5. Where is the pain/problem (location)?
_____
_____

6. What makes the pain/problem worse or better?
_____
_____

7. If painful, does the pain have a quality (sharp Vs dull)?
_____
_____

8. Please list any other associated problems that you have been having:
_____
_____

PAST MEDICAL HISTORY

Please list all of your medical problems (even if it is not related to your ENT problem):

_____
_____

Past Surgical History

Please list all surgeries that you have had (even if it is not related to your ENT problem):

_____
_____

SOCIAL HISTORY (AGE 18 AND OLDER)

Do you smoke? Yes/No
Did you ever smoke? Yes/No
How many alcoholic beverages do you consume each week? _____
Do you use any street drugs? _____

Social History (Age 17 and younger)
Is the patient exposed to second hand smoke? Yes/No
Is the patient in daycare? Yes/No
If any, please list the ages of all other siblings: _____
Please list any pets in the house: _____

FAMILY HISTORY

Please list any health problems that affect your parents and siblings:

_____
_____

Does anyone in your family have any bleeding problems? Yes/No
If yes, please list: _____

Medications
Please list all medications that you are taking (including over-the-counter medications such as aspirin and herbal supplements):

_____
_____

ALLERGIES

Please list any medication allergies, and describe the reaction that you had with each medication:

_____
_____

REVIEW OF SYSTEMS

Constitutional	Circle One
Weight loss	Yes No
Weight Gain	Yes No
Changes in sleep	Yes No
Fatigue	Yes No
Night sweats	Yes No
Fever/Chills	Yes No
Pain	Yes No

Head and Neck	
Nose bleeds	Yes No
Throat pain	Yes No
Difficulty swallowing	Yes No
Nasal congestion	Yes No

Neurological	
Memory changes	Yes No
Numbness	Yes No
Blurred vision	Yes No
Headaches	Yes No
Seizures	Yes No

Respiratory	Circle One
Shortness of breath	Yes No
Wheezing	Yes No
Cough	Yes No
Coughing up blood	Yes No

Genitourinary	
Pain with urination	Yes No
Urinating frequently	Yes No
Blood in urine	Yes No
Incontinence	Yes No

Musculoskeletal	
Joint pain	Yes No
Joint stiffness	Yes No
Muscle weakness	Yes No

Skin	
Rash	Yes No
Open sores	Yes No
Changes in moles	Yes No

CARDIOVASCULAR

Chest pain	Yes No
Irregular heartbeat	Yes No
Lower leg swelling	Yes No

Gastrointestinal	
Abdominal pain	Yes No
Nausea/vomiting	Yes No
Loss of appetite	Yes No
Acid reflux	Yes No
Vomiting blood	Yes No

Psychologic	
Depression	Yes No
Anxiety	Yes No

Endocrine	
Feel too hot	Yes No
Feel too cold	Yes No
Hair loss/thinning	Yes No
Weight gain	Yes No

Hematologic	
Easy bruising	Yes No
Excessive bleeding	Yes No
Blood clots	Yes No

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

_____ _____
Patient signature Date

_____ _____
Physician signature Date