Full Name: _____
Date of Birth: _____
Address: _____
_____
_____

Social Security Number: _____ - _____ - _____
Gender: M F
Primary Phone: _____
Mobile Phone: _____
Work Phone: _____

Email Address ***(required)***: _____

Relationship Status: S M D W Other

Your Employment: _____

Providers:
Primary Care Physician: _____
Referring Physician: _____
Pharmacy Name and City: _____

Social History:
Smoking: Are you a: Non-Smoker Current Smoker Former Smoker

Family History:
Do you have a family history of Thyroid Disease? Y N If yes, which relative? _____
Do you have a family history of skin cancer? Y N If yes, which relative? _____

We will review your medications, allergies, and medical/surgical history in the exam room

Patients 64+ Only

Do you have a health care proxy? (a legal document appointing someone to make healthcare decisions on your behalf)

- ☐ Yes ➢ Please provide details below
  - Name: _____
  - Phone #: _____
- ☐ No

Do you have a living will? (a legal document that spells out medical treatments you would and would not want to be used to keep you alive)

- ☐ Yes ➢ **Please circle:**
  - Full Code
  - Do not intubate
  - Do not resuscitate
- ☐ No

HEALTH HISTORY

Name _____ Date of Birth _____

Date _____ Pharmacy _____

Current Medications (including prescriptions, over the counter drugs and supplements)

_____ _____

_____ _____

_____ _____

_____ _____

Do you take aspirin? ❑ YES ❑ NO

Are you allergic to any medications? ❑ YES ❑ NO If yes please list below.

_____ _____

What was your reaction? (rash, hives, anaphylaxis, shortness of breath, etc.)

_____

List Food & Environmental Allergies

_____

_____

Have you ever had surgery? ❑ YES ❑ NO

If yes please list below.

_____

_____

_____

Hospitalization/Accidents Illness? ❑ YES ❑ NO

If yes please list below.

_____

_____

_____

Do you have any pins, screws or plates? ❑ YES ❑ NO

General Medical History

Have you ever had:	Yes	No
AIDS or HIV	❑	❑
Asthma or any lung problems	❑	❑
Bleeding Tendency	❑	❑
Blood or Plasma Transfusion	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Drug Addiction	❑	❑
Heart Disease/Mitral Valve	❑	❑
Heart Surgery	❑	❑
Pacemaker	❑	❑
Hepatitis or Cirrhosis	❑	❑
High Blood Pressure	❑	❑
Kidney Disease	❑	❑

Have you ever had:	Yes	No
Stomach Ulcer	❑	❑
Tuberculosis	❑	❑
IV Contrast Reaction	❑	❑
Multiple Sclerosis	❑	❑
Cystic Fibrosis	❑	❑
Muscular Dystrophy	❑	❑
Seizures	❑	❑
MRSA	❑	❑

Social History

	Yes	No	How much
Alcohol Use	❑	❑	_____
Caffeine Use	❑	❑	_____
Tobacco Use	❑	❑	_____
Substance Use / Recreational Use	❑	❑	_____

Family History

	Yes	No	Who?
Heart Disease	❑	❑	_____
Cancer	❑	❑	_____
High Blood Pressure	❑	❑	_____
Stroke	❑	❑	_____
Seizures	❑	❑	_____
Thyroid Disease	❑	❑	_____
Bleeding Tendencies	❑	❑	_____
*Anesthesia Complications	❑	❑	_____

*Please explain _____

Referred by: _____

If due to an accident: Date of accident _____ Where and how accident occurred _____

_____

Signature _____

Grand Island ENT
Conditions of Office Visits

Print Patient Name: _____ **SSN:** ____-___-____ **Date of Birth:** ___/___/____

1. CONSENT FOR TREATMENT
I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures including, but not limited to, laboratory testing, physical examination and such medical treatment as deemed necessary by my health care providers. Photos may also be taken of you and your condition and placed in your medical record for patient care purposes. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at GRAND ISLAND EAR NOSE THROAT.

2. AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize GRAND ISLAND EAR NOSE THROAT to furnish from my medical records any requested information or excerpts to any insurance company or third-party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (medical specialist, hospital, radiology, oncology, pathology, imaging center, skilled nursing facility, health care facility etc.)

3. FINANCIAL AGREEMENT
I agree, whether I sign as the patient or the legal representative of the patient that in consideration of the services rendered to the patient, that I individually obligate the patient and myself to pay the account. Arrangements that are different from this must be made with the office. If charges are denied for any reason by my insurance company I am liable for all charges for my visits at GRAND ISLAND EAR NOSE THROAT.

For more complete description of the potential uses and disclosure of your health information for treatment, payment and healthcare, refer to GRAND ISLAND EAR NOSE THROAT'S Notice of Privacy Practices.

I understand that I have the right to review the Notice of Privacy Practices prior to signing the consent. The terms of the Notice of Privacy Practices may change and you may write to our address for a revised copy.

You have the right to request that the provider restrict how your health information is used or disclosed to carry out treatment, payment, or healthcare operations; however GRAND ISLAND EAR NOSE THROAT is not required to agree to requested restrictions.

You have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on it.

5. FINANCIALLY RESPONSIBLE PARTY ☐ **Same as patient (if different, please complete section below)**

Name _____ Relationship to patient: ☐ Parent ☐ Guardian ☐ Other (specify)_____

Address _____ Phone Number (___) ____-_____

Date of Birth ___/___/____ Social Security Number _____-___-_____ Place of Employment_____

6. EMERGENCY CONTACT

Please list an emergency contact person: _____

Relationship: _____ Phone Number (___) ____-_____

Can we release Protected Health Information to this person: ☐ Yes ☐ No

7. OTHER INFORMATION:

May we contact you or leave a message on your home phone or cell phone regarding your health care issues? ☐ Yes ☐ No

Patient's Place of Employment_____

Please list an email to access your online portal: _____

8. NO SHOW POLICY: 1st no show – no charge
Any no show after there will be a fee of $30.00

UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON THE BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS

9. Signed: _____ **Date:** _____ **Witness:** _____

Relationship to Patient: _____ **Phone Number** (___) ____-_____