

Virginia ENT - PATIENT INFORMATION

Name (First, MI, Last):		Date of Birth:	Sex:
Address One:		Social Security#:	
Address Two:		Referring Physician:	
City:		Primary Care Physician:	
State:	Zip:	➤ Email Address:	
Home Phone #:		Emergency Contact:	
Work Phone #:		Emergency Contact Phone #:	
Cell Phone #:		Emergency Contact Relationship:	
Race: American Indian/Alaska Native ___; Asian ___; Black/African American ___; Native Hawaiian/Other Pacific Islander ___; White ___ Other _____			
Ethnicity: Hispanic/Latino ___; Non-Hispanic/Non-Latino ___			
Preferred Language: English ___; Spanish ___; Other (please specify) _____			

GUARANTOR INFORMATION [The person responsible for the bill]

Name:		Date of Birth:	Sex:
Address One:		Employer:	
Address Two:		Employer Address:	
City:		Employer City:	
State:	Zip:	Employer State:	Zip:
Home Phone #:		Work Phone #:	
Cell Phone #:			

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Policy ID #:		Policy ID #:	
Group #:		Group #:	
Group Name:		Group Name:	
Policyholder:		Policyholder:	
Date of Birth:	Sex:	Date of Birth:	Sex:
Social Security #:		Social Security #:	

➤ May we contact you via email w/periodic health information, announcements or patient surveys? Yes ___ No ___
(If yes, make sure you filled out your e-mail address above. We will not give it out or use it unnecessarily)

How did you hear about Virginia Ear, Nose & Throat Associates? _____

Virginia ENT - PATIENT HISTORY

Name: _____ **Age:** _____ **Date of Birth:** _____

Referring MD: _____ **Primary Care MD:** _____

Pharmacy of Choice (include name & location): _____

Please state the reason for your visit [Note: If you are here for **dizziness** please complete the Dizziness Questionnaire before you are called back to see the MD]: _____

Medication Allergies (please list): **None**

Family Medical History: Does anyone in your family have any of the following? **None** **Do not know**

Allergies	Asthma	Hearing Loss	Throat Cancer
Anesthesia Difficulty	Bleeding Problems	Heart Disease	Diabetes

Medical & Surgical History: Please list **ALL** your medical problems & previous surgeries **None**

- If you are over 65, have you ever had a Pneumonia Vaccine? ___ Yes ___ No ___ NA
- If you are over 50, have you ever had the Flu Vaccine? ___ Yes ___ No ___ NA
- If you are a woman 40 – 69 years old have you had a mammogram in the past year? ___ Yes ___ No ___ NA

Social History: **YES** **NO**

Cigarettes – Never smoked			
Former smoker		Year began:	Year quit:
Current smoker		Packs per day:	Year began:
Other Tobacco		Amount per day:	Year began: Year quit:
Alcohol		Drinks per week:	
Caffeine		Drinks per week:	
Day Care Participation			
Cigarette Smoke Exposure			

Current Medications (please list **ALL**): **None**

Review of Systems: Please place a check mark beside **ALL** of the following items that pertain to you.

General	Respiratory	Neurological	Gastrointestinal
Prematurity	Asthma	Meningitis	Heartburn, reflux
Late development	Chronic cough	Facial pain	Vomiting
Eating disorders	Sleep apnea	Seizures	Difficulty swallowing
Fever	Snoring	Dizziness	Genitourinary
Anorexia	Cardiovascular	Headaches	Pregnant, currently
Fatigue	Murmur	Auras	Absence of menstruation
Significant weight change	Heart defect	Stroke	Prostate problems
Skin	Irregular heart beat	Fainting	Hematology
Skin cancer	Shortness of breath	Endocrine	Abnormal bleeding
Change in wart/mole	Hypertension	Diabetes	Anemia
Eyes	Chest pain	Failure to grow	Blood clots
Double vision	Leg pain or swelling	Thyroid problems	Nose bleeds
Blurred vision			
Eye pain			