

# VALLEY EAR, NOSE & THROAT ASSOCIATES, P.C.

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security# \_\_\_\_\_ Marital Status \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Home Address & PO Box (if applicable) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Alternate Phone# \_\_\_\_\_  
Can we leave a message here? Circle One YES NO \_\_\_\_\_ Can we leave a message here? Circle One YES NO \_\_\_\_\_

Name of Parent or Legal Guardian (if under 18 years of age) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Emergency Contact (Name & Phone Number) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Family Physician \_\_\_\_\_ Office Address \_\_\_\_\_ Office Phone# \_\_\_\_\_

Name(s) of Insurance(s) \_\_\_\_\_ Insured's Employer(s) \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

\*Referring Physician (if different than family doctor) \_\_\_\_\_

In order to provide quality medical care for our patients, please note the following policy of this office:  
If a patient misses three scheduled appointments with our office, fails to comply with our recommended instructions, or becomes abusive towards our staff, we will be forced to dismiss that patient from our care.

1. I authorize all medical information to be released to the Insurance Company and payment be made to Valley Ear, Nose, & throat Associates, P.C.
2. I understand payments (i.e. co-payments) are due at the time services are rendered.
3. I understand that if I have a Master Medical policy, I am responsible for payment at the time services are rendered.
4. I understand that it is my responsibility to obtain an **insurance referral for each** visit if I am a member of an HMO.
5. I understand that Medicare will not pay for any procedure that is determined cosmetic and therefore payment is my responsibility. Consider this as my "ONE TIME AUTHORIZATION AGREEMENT" to permit payment of Medicare benefits to VALLEY ENT ASSOCIATES, P.C.
6. I understand that if the provider's charge exceeds the insurance payment, or if my insurance denies payment, I will be responsible for the amount.
7. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

By signing, I acknowledge that I have read all of the above statements.

PLEASE COMPLETE IN INK  
DO NOT WRITE ON BACK OF FORM - ATTACH  
ADDITIONAL SHEETS IF NECESSARY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD  
DIFFICULTY WITH THE FOLLOWING:

Breathing out of the nose \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Stiffness in the nose \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Sinus Congestion \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Headache in the sinus area \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Post-nasal drainage \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Disturbance in smell \_\_\_\_\_ Yes \_\_\_\_\_ No

Throat infections \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Sore throats \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Chronic cough \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Difficulty swallowing \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Burning tongue \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Disturbance in taste \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Do you drink alcohol regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

Ear infections \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Itchy ears \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Buzzing/ringing in ears \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Dizziness \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Hearing problems \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Have you ever worn hearing aids? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If so, which ear? \_\_\_\_\_ Rt. \_\_\_\_\_ Lt.

Asthma \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Inhalant allergies \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Arthritis \_\_\_\_\_ Yes \_\_\_\_\_ No  
 What do you weigh? \_\_\_\_\_  
 Are you overweight? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 High cholesterol \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Heartburn/indigestion \_\_\_\_\_ Yes \_\_\_\_\_ No  
 High blood pressure \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Thyroid trouble \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Heart trouble \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Chest pain \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Stroke \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Heart attack \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Anemia \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Bleeding disorders \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Diabetes \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Hepatitis \_\_\_\_\_ Yes \_\_\_\_\_ No  
 HIV or AIDS \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Tuberculosis \_\_\_\_\_ Yes \_\_\_\_\_ No

\*List any medications you are taking:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

MEDICATION ALLERGIES?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please list:

\_\_\_\_\_  
 \_\_\_\_\_

HAVE YOU OR A FAMILY MEMBER HAD AN  
UNUSUAL REACTION TO ANESTHESIA?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LIST ANY HOSPITALIZATIONS & SURGERIES THAT  
YOU HAVE HAD:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

FAMILY HISTORY:

FATHER Alive \_\_\_\_\_ Deceased \_\_\_\_\_  
 Cause of death \_\_\_\_\_

MOTHER Alive \_\_\_\_\_ Deceased \_\_\_\_\_  
 Cause of death \_\_\_\_\_

NUMBER OF SIBLINGS:

Alive \_\_\_\_\_ Deceased \_\_\_\_\_