Ear Nose & Throat
OF SPRINGFIELD
Quality care, close to home.

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Patient Information Chart #

Date | Pharmacy | Race* | Ethnicity *

Patient Name | Birthdate | Age | Sex

Address | Preferred Language

City | State | Zip | Marital Status

Home Phone | Cell Phone | Work Phone

SSN # | Employer | Occupation

Family Doctor | Referring Doctor

Emergency Contact | Phone Number

Responsible Party Information (If other than Patient) -- Person signing this form must be 18 or older

Name | Billing Name

Relation to Patient | Billing Address

City | State | Zip | Date of Birth

SSN # | Home Phone | Work Phone

Insured SSN# (if other than responsible party)

Primary Ins. | Policy Holder

Ins. Address | Insured Address

Policy ID # | Relation to Patient

Group # | Copay $ | Date of Birth

Secondary Ins | Policy Holder

Ins. Address | Insured Address

Policy ID # | Relation to Patient

Group # | Copay $ | Date of Birth

*Note: We are now required by Government to ask for Race and Ethnicity, but providing it remains your decision.

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What is your email address?

**Providing your email address will enable us to send you an invite to join our new patient portal.*

Who is authorized to share your medical information if requested?

By your signature, you are authorizing ENT of Springfield to serve on your behalf as representative to your insurance carrier. This includes, but is not limited to, the release of medical information and the request that payment be made directly to ENT for services rendered. It is also understood that you abide by ENT's Financial Policy, as printed on the next page. You may request a copy for your records. You are also indicating that you have been furnished with a copy of the Health Information Privacy Rights.

Signature of Responsible Party

Date

Annual update of Responsible Party

Date

Annual update of Responsible Party

Date

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Date:
Patient Name:
Age:
Date of Birth:

Patient Medical History (past and current)

- ☐ Allergies
- ☐ Hearing loss
- ☐ Cancer (type):
- ☐ Anemia (type):
- ☐ Arthritis (type):
- ☐ Asthma
- ☐ Anxiety and/or Depression
- ☐ Bleeding disorder (type):
- ☐ Diabetes (type):
- ☐ Emphysema
- ☐ COPD
- ☐ GE Reflux, heartburn
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Heart condition (type):
- ☐ Congestive Heart Failure
- ☐ Heart Attack / MI
- ☐ Pacemaker, Defib
- ☐ Kidney problem (type):
- ☐ Neurological problem (type):
- ☐ Other lung problem (type):
- ☐ Liver problem (type):
- ☐ Thyroid problem (type):
- ☐ HIV, Infectious disease
- ☐ Tuberculosis/TB
- ☐ Stroke/CVA
- ☐ Seizure disorder
- ☐ Other:

Family Medical History

	Who?	Maternal	Paternal
☐ Bleeding disorder		◯	◯
☐ Cancer		◯	◯
☐ Asthma		◯	◯
☐ Diabetes		◯	◯
☐ Heart Disease		◯	◯
☐ Stroke		◯	◯
☐ Anesthesia problem		◯	◯
☐ Hearing loss		◯	◯
☐ Other:		◯	◯

☐ist ☐rug Allergies

☐ocial History

Tobacco use: Yes, currently ◯ No, never ◯ I have in the past ◯

What kind?
How much?
How long?
If you ☐uit☐when?

☐o you drink alcohol?
☐o you ☐currently or in the past☐use recreational drugs?
How much caffeine do you drink a day?

Occupation☐
Hobbies☐

Medications ☐ist all medications you are taking☐including over the counter and herbal

☐ame ☐ose

☐urgical History

Anesthesia Problems?
If yes☐e☐plain.

Height
Weight

Print

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COMPREHENSIVE REVIEW OF SYSTEMS

Please mark if you have any of the following:

HENT:

Headache	☐Yes	☐No
Nasal congestion	☐Yes	☐No
Hearing loss	☐Yes	☐No
Ringing in the ears	☐Yes	☐No
Dizziness	☐Yes	☐No
Nasal discharge	☐Yes	☐No
Difficulty swallowing	☐Yes	☐No
Hoarseness	☐Yes	☐No
Postnasal Drip	☐Yes	☐No
Lightheadedness	☐Yes	☐No

Cardiovascular:

Chest Pain	☐Yes	☐No

Respiratory:

Shortness of breath	☐Yes	☐No
Cough	☐Yes	☐No

Gastrointestinal:

Nausea/Vomiting	☐Yes	☐No

Genitourinary:

Difficulty urinating	☐Yes	☐No

Integument:

Rash	☐Yes	☐No
New skin lesion	☐Yes	☐No

Musculoskeletal:

Muscular weakness	☐Yes	☐No

Neurological:

Loss of Balance	☐Yes	☐No

Psychiatric:

Anxiety	☐Yes	☐No
Depression	☐Yes	☐No

Heme-Lymphatic:

Easy bleeding/bruising	☐Yes	☐No

Allergic/Immunological:

Itchy nose/throat	☐Yes	☐No
Sneezing	☐Yes	☐No

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for ENT of Springfield to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by ENT of Springfield describes such issues and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ENT of Springfield reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Manager (privacy officer) of ENT of Springfield, 435 S. Burnett Rd, Springfield, OH 45505.

With this consent, ENT of Springfield may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO; such as, appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results.

With this consent, ENT of Springfield may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, ENT of Springfield may e-mail to me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ENT of Springfield restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree with my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am giving ENT of Springfield my consent to use and disclose my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this extent, or later revoke it, ENT of Springfield may decline to provide treatment to me.

Signature Date Relationship

Print Patient Name Print name of legal guardian (if applicable)