



Please tell us why you are here today: _____

Please list any allergies (drugs, foods, seasonal): _____

Please list current medications (Blood thinners, Antibiotics, Steroids, other): _____

Gender _____ Pronouns _____

PAST MEDICAL HISTORY:

Blood Disorders: None
 Anemia Blood Clots
 Deep Vein Thrombosis
Other: _____

Cancer: None
What kind? _____
Where is/was it located? _____

Endocrine: None
 Diabetes Hypothyroidism
 Hyperthyroidism
Other: _____

Digestive: None
 Gallstones Hepatitis
 Intestinal Problems Reflux/ Heartburn
Other: _____

Neurological Disorders: None
 Dementia/Memory Parkinson's
 Epilepsy Stroke/ TIA
Other: _____

PAST Surgical History: None
 Ear surgery Ear Vent Tubes Gallbladder Removal
 Hernia Heart Surgery Lung / Airway Surgery
 Septoplasty Sinus Surgery Tonsillectomy / Adenoidectomy

Have you ever had any complications with anesthesia? Yes No If yes, please explain _____

Child Social History (For patients under 18 years of age):

Are there pets in the home? Yes No Name of school: _____
Lives with both parents? Yes No How do they perform in school? _____
Parents smoke? Yes No Attend daycare? Yes No
Immunizations up to date? Yes No
Complications during pregnancy or deliver? Yes No If yes, please explain: _____

Heart Disease: None
 Angina / Chest Pain / Heart attack
 Arrhythmias Pacemaker
 High Blood Pressure
Other: _____

Allergy/Rheumatology: None
 Seasonal Allergies Food Allergies
 Arthritis Sjogren's Disease
Severe Allergic Reaction: _____

Respiratory / Lung: None
 Asthma / COPD Sleep Apnea
Other: _____

Integumentary / Skin: None
 Eczema Psoriasis
Other: _____

Urinary: None
 Bladder: _____
 Kidney: _____
Other: _____

Family History:

Mother Living Deceased Health problems: _____
Father Living Deceased Health problems: _____
Siblings Living Deceased Health problems: _____
Adopted Yes No

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of Northwest ENT & Allergy’s Notice of Privacy Practices. This notice describes how Northwest ENT & Allergy may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my health information.

Date: ____/____/____
(Signature of Patient or Guardian)

Consent to Release Health Information

I understand that Northwest ENT & Allergy will use, disclose, store and maintain health information about me. I understand that my health information may include information that is created or received by Northwest ENT & Allergy, may be in the form of written records, electronic records, or spoken words and may include information about my health history, health status, symptoms, exams, test results, diagnosis, treatment, procedures, prescriptions, and similar types of health-related information.

Date: ____/____/____
(Signature of Patient or Guardian)

Acknowledgement of No-Show & Cancellation Policy

A patient is considered a “No-Show” if they cancel within 24 hours of their appointment, or fail to show-up, or arrive 15 minutes after their scheduled arrival time. If you No-Show 3 times, we will not be able to put you back on the schedule.

Date: ____/____/____
(Signature of Patient or Guardian)

Financial Agreement

I am responsible for the full amount of my copayment and/or deductible payment at the time of service as determined by my insurance carrier, health plan or government program. Northwest ENT and Allergy will file an insurance claim on my behalf. I am responsible for the full payment of any outstanding balance. A \$50.00 charge will be added for all returned checks.

If uninsured, payment will be due in full at time of service.

I am responsible for any outstanding balance. If I default on my balance, I am responsible for all collection costs and attorney fees.

Date: ____/____/____
(Signature of Patient or Guardian)

Who can we talk to about your healthcare?

Name: _____ Relationship: _____ Phone #: _____

Medical Practices you would like us to talk to about your healthcare: _____

Date: ____/____/____
(Signature of Patient or Guardian)