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: ______________________________

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: ______________________________

PAST Surgical History: ◯ None

◯ Ear surgery ◯ Ear Vent Tubes ◯ Gallbladder Removal Other: ______________________________

◯ 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______________________________

Adult Social History (For patients 18 years of age and older):

Tobacco use? ◯ Current ◯ No ◯ Quit

Alcohol use? ◯ Yes ◯ No ◯ Quit

Illicit drug use? ◯ Yes ◯ No ◯ Quit

Packs a day? ________ Years of tobacco use? _________

Caffeine intake? ◯ Yes ◯ No

Number of children: _____________

Occupation: ______________________________

Family History:

Marital Status: ◯ Married ◯ Single ◯ Divorced

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)