PATIENT INFORMATION RECORD

PATIENT NAME_____ DATE_____
LAST FIRST MIDDLE INIT.

ADDRESS_____
STREET CITY STATE ZIP

DATE OF BIRTH_____ AGE _____ SOCIAL SECURITY #_____

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ PHARMACY NAME & PHONE _____ _____

EMERGENCY CONTACT/ RESPONSIBLE PARTY IF UNDER 18 YEARS _____

HOME PHONE # _____ WORK PHONE # _____

WHO REFERRED YOU TO OUR OFFICE? _____

PLEASE CHECK (IF APPLICABLE) ER ____ FAMILY____ FRIEND ____ INS. CO. ____ YELLOW PAGES ____ INTERNET ____

DID YOU LOCATE OUR PRACTICE FROM AN INTERNET WEB SEARCH? YES ____ NO ____

DID YOU DOWNLOAD FORMS FROM OUR WEB SITE? YES ____ NO ____ ARE YOU A PREVIOUS PATIENT? YES ____ NO____

FAMILY PHYSICIAN _____ ADDRESS _____

PHONE # _____ DO YOU WANT YOUR FAMILY PHYS. TO RECEIVE A REPORT OF THIS VISIT? YES ____ NO ____

IS IT POSSIBLE YOU MAY BE PREGNANT? YES ____ NO ____ N/A ____ ARE YOU NURSING A BABY? YES ____ NO ____ N/A ____

MEDICAL HISTORY: _____

SURGERY & APPROXIMATE DATES: _____

MEDICATIONS: Prescription and over the counter medications, herbs and vitamins_____

_____

ALLERGIES: Allergies to medications, foods, pollens, etc._____

_____

DO / DID YOU SMOKE OR USE SMOKELESS TOBACCO? YES ____ NO ____ PACKS/ DAY _____ DURATION _____

WHEN STOPPED (IF APPLICABLE) _____

DO YOU USE ALCOHOL? YES ____ NO ____ FREQUENCY _____

HAVE YOU OR ANY RELATIVE HAD THE FOLLOWING? PLEASE LIST "SELF" OR RELATION ON LINE

ALLERGY	NO _____	YES _____	**HEART PROBLEMS**	NO _____	YES _____
BLEEDING HISTORY	NO _____	YES _____	**HIGH BLOOD PRESSURE**	NO _____	YES _____
CANCER	NO _____	YES _____	**MIGRAINE HEADACHES**	NO _____	YES _____
DIABETES	NO _____	YES _____	**STOMACH ULCERS**	NO _____	YES _____
HEARING LOSS	NO _____	YES _____	**HEPATITIS / HIV**	NO _____	YES _____

PRIMARY REASON FOR TODAY'S VISIT: _____

WHAT STUDIES HAVE YOU HAD RELATED TO THIS VISIT? _____

STUDIES PERFORMED AT: _____

PATIENT INFORMATION RECORD

PATIENT NAME_____ DATE_____
LAST FIRST MIDDLE INIT.

Please Circle:

SEX: M F **MARITAL STATUS**: SINGLE MARRIED WIDOWED

EMPLOYMENT STATUS: EMPLOYED PART TIME STUDENT FULL TIME STUDENT RETIRED UNEMPLOYED

NAME OF RESPONSIBLE PARTY IF PATIENT IS UNDER AGE 18 _____

RELATIONSHIP TO PATIENT _____DATE OF BIRTH OF RESPONSIBLE PARTY _____

ARE YOU INTERESTED IN DISCUSSING COSMETIC PROCEDURES? YES ____ NO ____

REGARDING TODAY'S APPOINTMENT, IS YOUR CONDITION RELATED TO:

- YOUR EMPLOYMENT? YES ____ NO ____
- AUTO ACCIDENT? YES ____ NO ____
- OTHER ACCIDENT? YES ____ NO ____

PARTY TO CONTACT TO VERIFY CLAIM NUMBER:
_____

INSURANCE INFORMATION

**** MUST BE COMPLETED ****

PRIMARY INSURANCE PLAN

INS. NAME:_____
INS. TELEPHONE: _____
POLICY GROUP # _____
POLICY ID # _____

SUBSCRIBER NAME:
_____
ADDRESS:
_____
_____
PHONE: _____
RELATIONSHIP TO PATIENT: _____
SUSCRIBER SOCIAL SECURITY #
_____
SUBSCRIBER DATE OF BIRTH: _____

SECONDARY INSURANCE PLAN

INS. NAME:_____
INS. TELEPHONE: _____
POLICY GROUP # _____
POLICY ID # _____

SUBSCRIBER NAME:
_____
ADDRESS:
_____
_____
PHONE: _____
RELATIONSHIP TO PATIENT: _____
SUSCRIBER SOCIAL SECURITY #
_____
SUBSCRIBER DATE OF BIRTH: _____

*All charges incurred will be the responsibility of the patient, or that of his parents, guardian or agent.

AUTHORIZATIONS AND ACKNOWLEGEMENT

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY (ENTACC) FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND TO SECURE THE PAYMENT OF HEALTH BENEFITS. I UNDERSTAND THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID OR NOT PAID BY MY INSURANCE.

_____ _____
SIGNATURE OF INSURED OR RESPONSIBLE PARTY DATE

• PLEASE PROVIDE INSURANCE CARDS FOR PHOTOCOPYING •