E.N.T. ASSOCIATES OF WORCESTER, INC.

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PATIENT INFORMATION (PLEASE PRINT CLEARLY)

DATE:_____ SS#_____-____-_____ E-MAIL _____
LAST NAME:_____FIRST & INT'L_____
MAILING ADDRESS_____
CITY_____STATE_____ZIP CODE_____

DATE OF BIRTH _____LANGUAGE_____ETHNICITY_____
RACE_____MARITAL STATUS _____SEX_____
(CIRCLE ONE)

PLEASE LIST DAYTIME PHONE (____)_____ CELL/WORK/HOME
SECONDARY PHONE (____)_____ CELL/WORK/HOME/OTHER

EMERGENGY CONTACT:
NAME:_____PHONE (____)_____RELATIONSHIP_____

PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME: _____ **ADDRESS:** _____

GUARANTOR INFORMATION (IF MINOR)
LAST NAME:_____FIRST NAME & INITIAL_____
ADDRESS:_____SS#_____-____-_____
CITY:_____STATE_____ZIP CODE:_____DATE OF BIRTH_____

PRIMARY INSURANCE CARD HOLDER
LAST NAME:_____FIRST NAME:_____
DATE OF BIRTH:_____

****IS THIS APPOINTMENT WORKER'S COMP OR ACCIDENT RELATED? YES or NO**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/TO RELEASE INFORMATION: I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS.

_____ _____
PATIENT SIGNATURE (PARENT IF MINOR) **DATE**

OVER FOR PAGE 2

NAME: _____

CHIEF COMPLAINT

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

HEIGHT: _____ **WEIGHT:** _____

PAST SURGERIES: (PLEASE CHECK ALL THAT APPLY)

_____ TONSILLECTOMY
_____ APPENDECTOMY
_____ HERNIA REPAIR
_____ CHOLECYSTECTOMY(GALLBLADDER)
_____ KNEE REPLACEMENT (RIGHT / LEFT)
_____ HIP REPLACEMENT (RIGHT / LEFT)
_____ **OTHER** _____
_____

PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

_____ HEART ATTACK
_____ HEART DISEASE
_____ HIGH CHOLESTEROL
_____ HIGH BLOOD PRESSURE
_____ HEART MURMUR
_____ PNEUMONIA
_____ TUBERCULOSIS
_____ ASTHMA
_____ HEPATITIS
_____ HIV
_____ BLOOD TRANSFUSIONS
_____ IRREGULAR HEARTBEAT
_____ ACID REFLUX
_____ ADD/ADHD
_____ ALZHEIMER'S
_____ ANEMIA
_____ANEURYSM
_____ AUTISM
_____ CANCER
_____ CLOT FACTOR DEFICIT
_____ CLEFT PALATE
_____ COPD
_____ DEMENTIA
_____ DIABETES
_____ ECZEMA
_____ EMPHYSEMA
_____ GLAUCOMA
_____ LYME DISEASE
_____ MIGRAINES
_____ MS
_____ RHEUMATIC FEVER
_____ SUBSTANCE ABUSE
_____ PACEMAKER
_____ OTHER_____
_____

REVIEW OF SYSTEMS: (PLEASE CHECK ALL THAT APPLY AT THIS TIME)

_____ RECENT CHEST PAIN
_____ SHORTNESS OF BREATH
_____ EASY BRUISING
_____ EASY BLEEDING
_____ TREMORS
_____ FEVER
_____ VOMITING
_____ PAIN/BLOOD W/URINATION
_____ MUSCLE CRAMPS
_____ EYESIGHT PROBLEMS
_____ PREGNANCY
_____ PALPITATIONS
_____ WHEEZING
_____ FATIGUE

FAMILY HISTORY:

	MOTHER	FATHER	SISTER	BROTHER	MGM	MGF	PGM	PGF
HEART ATTACK								
HEART DISEASE								
ASTHMA								
COPD								
EMPHYSEMA								
CANCER								

IF THE PATIENT IS A DEPENDENT WITH WHOM DO THEY LIVE?_____

SOCIAL HISTORY:

DO YOU SMOKE? _____ IF YES HOW MANY PACKS PER DAY _____ FOR HOW MANY YEARS? _____
DID YOU SMOKE PREVIOUSLY? _____ WHEN DID YOU QUIT? _____ CHEWING TOBOACCO? _____
ALCOHOL USE: YES or NO. IF YES, HOW MUCH PER DAY: BEERS_____
GLASSES OF WINE_____HARD LIQUOR_____.