CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

Name: ____

Date of Birth: ______________________ **Age**: ____________

Primary Care Doctor (Name and Location):____

Who referred you to our office? :____

How can we help you today: ____

Have you had a Flu Vaccine? Yes [ ] No [ ]
Have you had a Pneumonia Vaccine? Yes [ ] No [ ]

Please List your Past Medical History: ____

____

____

____

For Women: Is there a possibility you are pregnant? Yes [ ] No [ ]

Have you had any of the following surgeries? [ ] I have never had Surgery
[ ] Septoplasty [ ] Ear Tubes [ ] Thyroidectomy [ ] Cosmetic Surgery
[ ] Sinus Surgery [ ] Tonsillectomy [ ] Other Head and Neck Surgery
[ ] Ear Surgery [ ] Adenoidectomy [ ] Dental Surgery
Please list ALL other surgeries: ____

____

____

____

Family Medical History:
Indicate which family member beside each condition: (M) mother (F) father (C) child (B) brother(S) sister
Example: M allergies
___ Allergies _____ Bleeding Disorder _____ Migraine _____ Cancer type: _____________

___ Diabetes _____ Heart Disease _____ Thyroid Disorder __________________________

___ Hearing Loss _____ Stroke _____ Asthma [ ] Unknown/Adoption

Mother: [ ] Alive [ ] Deceased Cause of Death___________________

Father: [ ] Alive [ ] Deceased Cause of Death ___________________

(Please turn over)

Social History: (age 13 and above)

Do you currently use tobacco products? [ ] Yes [ ] No If yes what type? ______________________

How much a day? ____________ For how many years? _____________

Have you previously used tobacco products? [ ] Yes [ ] No If so what type? __________________

When did you quit? ____________ For how many years? _______________

Do you use recreational drugs? [ ] Yes [ ] No If yes what type? ________________________

Do you drink alcohol? [ ] Yes [ ] No If yes how much per week? ________________________________

Do you drink caffeinated beverages? [ ] Yes [ ] No If yes what type? _________Weekly amount? ______

Have you had chemical exposure? [ ] Yes [ ] No

Have you had or do you have excessive noise exposure? [ ] Yes [ ] No If yes what type?_______________

Do you have any pets in the home? [ ] Yes [ ] No If yes what type? ________________________________

Current occupation? ______________________________

REVIEW OF SYSTEMS: Do you have any of the following symptoms:

Constitutional:	☐fever	☐weight loss	☐fatigue	☐ daytime sleepiness
Eye:	☐vision loss	☐double vision	☐floaters	☐flashes of light
Ear, Nose, Mouth, Throat:	☐hearing loss	☐snoring	☐nasal bleeding	
Cardiovascular:	☐chest pain	☐palpitations	☐passing out	☐shortness of breath
Pulmonary:	☐dry cough	☐productive cough	☐wheezing	☐coughing up blood
Gastrointestinal:	☐heartburn	☐constipation	☐diarrhea	☐trouble swallowing
Genitourinary:	☐blood in urine	☐weak urine flow		☐painful urination
Musculoskeletal:	☐joint pain	☐joint swelling	☐muscle aches	☐swollen feet
Integumentary/skin:	☐rash	☐itchy ears	☐non-healing wound	
Neurologic:	☐dizziness	☐weakness	☐headache	☐memory loss
Psychiatric:	☐depression	☐anxiety	☐claustrophobia	☐panic attacks
Endocrine:	☐heat intolerance	☐cold intolerance	☐frequent urination	
Hematologic/lymphatic:	☐easy bruising	☐swollen glands	☐bleeding	
Allergy/immunologic:	☐spring allergies	☐fall allergies	☐summer allergies	☐winter allergies.

I certify that to the best of my knowledge, the above information is complete and accurate.

Patient or guardian's signature: ____ Date: _______________

Reviewing physician's signature: ____ Date: _______________

CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

Name: ____

Date of Birth: __________________________________

Local Pharmacy Name: ___________________________ **Town:** ________________________________

Mail Away Pharmacy: ____

Are you allergic to Latex, adhesive tape or rubber? [ ] Yes [ ] No

Do you have any know drug allergies? If none check here [ ]

Please list any drug allergies along with reaction: ____

____

____

Medication List

(Please list all medications including vitamins, OTC medications and prescription marijuana)

NAME OF MEDICATION	DOSAGE	WHAT IS MED TAKEN FOR?

Do we have your consent to retrieve Rx history from external source? [ ] No, If yes please sign below:

Sign Name: ____________________________________ Date: __________________________________

CAPE COD EAR, NOSE AND THROAT SPECIALISTS
HEAD & NECK SURGERY, P.C.

Welcome to our Office!

Please complete both sides and present a copy of your photo ID and insurance card.

Patient Information:

Last Name: ____________________ First Name: ______________ MI: __

Date of Birth: ____________________ Age: __________ M/F: __________

Mailing Address: ____

City/State/Zip: ____

Phone: ____________________________ Cell: ____________________

Email: ______________________________ Social Security #: ____________

Primary Care Physician/Pediatrician: ______________________________

Employer: ____

Was your injury due to Motor Vehicle Accident? Y / N Work Related Injury? Y / N

Race: American Indian or Alaska Native ( ) White ( ) Asian ( )
Black or African American ( ) Native Hawaiian/Pacific Islander ( )
Hispanic ( ) Other ( )

Ethnicity: Hispanic or Latino ( ) Not Hispanic or Latino ( )

Insurance Information:

Primary Insurance: ____

Insured's Name: ____

Patient's Relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Holder's Birthdate: ______________ S.S. #: ________________

Secondary Insurance: ____

If patient is under 18 years of age:

Parent/Guardian Name: ______________________ S.S. #: ______________

Address: ________________________________ DOB: ______________

FINANCIAL AGREEMENT

I understand that I am financially responsible for charges for services rendered. This includes the balance after insurance has paid or denied, including deductibles, copays and co-insurance.

ASSIGNED BENEFITS

I request that payment of authorized medical benefits be made on my behalf directly to CCENT for services rendered. I authorize any holder of medical information regarding me be released to my insurance company or health plan and its agents and any information needed to determine these benefits payable for related services.

If claims are to be submitted to the insurance carrier for my visits, complete information is required along with any referrals required by my insurance carrier. If I am unable to provide this information, payment will be expected at time of visit for services rendered. An office co-pay is due the time of the visit. Any procedure performed in office may be considered by my insurance carrier as surgery and may have a separate deductible.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid and original.

I have read this information and understand it:

Name: ____Date: __________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of the Notice of Privacy Practices of Cape cod Ear, Nose and Throat Specialists-Head & Neck Surgery, P.C. and/or the opportunity to review the Notice of Privacy Practices and retain a copy. This agreement will expire 7 years after your last office visit.

Printed Name: ______________________________________Date: ___________________

Signature of Patient or Legal Representative: ____

Patient's Relationship to Legal Representative: ______________________________________

The Patient or the Patient's Legal Representative did not provide a written acknowledgment of receipt of the Notice of Privacy Practice's. The following explains the good faith efforts to obtain the written acknowledgment and the reasons why the acknowledgment was not obtained: __________________

____.

RELEASE OF INFORMATION

Please list all **non-medical** persons that our doctors/staff may speak to regarding you or your child's medical care (i.e. Spouse, significant other, sibling etc.):

Names: ______________________________ ___________________________________

VOICE MAIL RELEASE

I give permission to have test results or responses to my inquiries etc. be left as a voice mail on my provided phone numbers.

Signature of Patient or Parent/Guardian: ________________________Date: _______________

Cape Cod Ear Nose and Throat Specialist does not utilize e-mail for transferring medical records.