Ear, Nose, Throat & Plastic Surgery Associates, P.C.

NEW PATIENT PACKET

Today's Date: _____

Patient Name: _____ DOB: _____

Social Security #: _____ Sex: Male Female

Address: _____

City/State/ZIP: _____

Phone: _____ (home) _____ (cell) _____ (work)

Email Address: _____

- Preferred Method for Office Reminders: Home Phone Cell Phone Work Phone Email
- Marital Status: Single Married Divorced Widowed Minor
- Work Status: Employed Unemployed Retired Minor/Student

Employer: _____ Occupation: _____

PCP/Family Doctor: _____ Phone: _____

Referring Physician: _____ Phone: _____

Reason for your visit: _____

Emergency Contact: _____

Relationship to Patient (other than parent/guardian): _____ Phone: _____

Pharmacy: _____ Phone: _____

Crossroads/City: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____ Member ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

PARENT/GUARDIAN INFO FOR MINOR PATIENT

Name(s): _____ DOB: _____

Relationship to Patient: _____ SSN: _____

Address: _____ Phone: _____

(OVER)

MEDICAL HISTORY

Have you had any of the following, currently or in the past? (circle all that apply)

Hypertension / Diabetes / Kidney Disease / Pulmonary Disease / High Cholesterol / Stroke / Blood Clots / Asthma / COPD / Seizures / Ulcers / Arthritis / Osteoporosis / Pace Maker / Cancer: _____

Other medical conditions: _____ _____

_____ _____

Do you have a family history of: Ear Surgery Hearing Loss Other Ear Problems None

Height: _____ **Weight**: _____

Current Medications: (include strength and how often per day. Attach list if necessary.)

_____ _____

_____ _____

_____ _____

Allergies: (include medications, food, seasonal, animal, latex, iodine, etc.) ☐ No Known Allergies

_____ _____

_____ _____

_____ _____

Hospitalizations and Surgeries: (include date, hospital, and surgery/admit reason.)

_____

_____

_____

QUALITY REPORTING FOR CMS

The Centers for Medicare and Medicaid (CMS) are teaming up with physicians to improve the level of healthcare you receive. The following questions are a part of the data that CMS is collecting to evaluate trends in healthcare. Your personal information will not be reported with this data as the data is sent as numbers only. Thank you for your cooperation!

Do you currently use tobacco products? YES or NO

Have you used tobacco products in the past that you no longer use? YES or NO

Date of last Flu Vaccine: _____

Date of last Mammogram: _____ Date of last PAP smear: _____

Have you had a pneumonia vaccination? YES or NO If yes, when? _____

If you are between the ages of 50 and 75, have you ever had the following colorectal cancer screenings?

Colonoscopy: YES or NO If yes, when? _____

Sigmoidoscopy: YES or NO If yes, when? _____

Fecal occult blood test: YES or NO If yes, when? _____