Patient Information Form

We appreciate you taking the time to fill out these forms. Please print clearly and answer completely.

Full Legal Name ____ Nickname ________________________

☐ Male ☐ Female

Home Phone____________________________

Address ____

Cell Phone ______________________________

City ____________________ State ______ Zip ___________

Work Phone ____________________________

Date of Birth _______________________________________

SSN ____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email ____

Employer ____

Race ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Other

Ethnicity ☐ Hispanic ☐ NOT Hispanic

Primary Language __________________________________

Which Doctor referred you to our office? (*First & Last Name*) ____

Who is your Primary Care Doctor? (*First & Last Name*) ____

What is your preferred pharmacy? (*Name & City*)____

Parent or Responsible Party Information

This portion needs to be filled out **ONLY** if the patient is age 17 years and younger. The responsible party is who fills out these forms.

Parent/Guardian Name ____Date Of Birth ________________

Address ____ ☐ Male ☐ Female

City ______________________ State _________ Zip ____________

Primary Phone # ____

Employer ________________________ Employment Status ☐ Part Time ☐ Full Time

Patient's relationship to Responsible Party _______________________________________

Health Insurance Information

Despite our office scanning your cards, this section *still* needs to be filled out completely. If we do not have all information we need, we cannot bill your insurance correctly. Please answer all of the following…

PRIMARY INSURANCE

Company ______________________________________

Address ______________________________________

Subscriber Name _______________________________

Subscriber D.O.B _______________________________

Subscriber I.D __________________________________

Group Name ___________________________________

Group # ______________________________________

Relationship to Patient ____________________________

SECONDARY INSURANCE

Company ____

Address ____

Subscriber Name ____________________________________

Subscriber D.O.B ____________________________________

Subscriber I.D. ______________________________________

Group Name ____

Group # ____

Relationship to Patient________________________________

Patient Name ____Date Of Birth_______________________

Release of Medical Information

By signing below, (see ***X*** below) I authorize the doctors and staff at Peak ENT and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostics tests and lab results to the below-named persons (e.g. spouse or parent.) This authorization shall be effective until I revoke in writing.

Individual # 1 ________________________________ Individual #2 ______________________________________

Relationship to Patient _________________________ Relationship to Patient _______________________________

Financial Policy & Notice of Privacy Practices

I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at the time of service**. I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee up to 40% of the principal amounts owing as allowed by Utah Code annotated, sec. 12-1-11 in addition to any other amounts, such as interest, attorney fees or court costs. **I understand that some medical services performed in the office (audiology tests, ultrasounds, biopsies, CT scans, scopes, ear cleanings, and other procedures, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

X Patient/Resp. Party Signature____ ***Date*** _________________

Emergency Contact *(not living with you)*

Name _____________________________________Relationship _________________ Phone____________________

Address ______________________________________ City _______________________ State _____ Zip___________

MEDICAL HISTORY FORM

Name:__________________________________ Age:_______ Date of Birth_____/_____/________

Date symptoms started:_____________________ Primary reason for visit:______________________________

LIST ALL DIAGNOSED MEDICAL CONDITIONS

☐ Hypothyroidism ☐ Hyperthyroidism
☐ Thyroid Nodules ☐ Parathyroid disorder
☐ Thyroid Cancer

____
____
____
____
____

LIST ALL PREVIOUS SURGERIES

☐ Thyroidectomy: *(date)*______________________________

☐ Parathyroidectomy: *(date)*_________________________

☐ Hysterectomy: *(date)*______________________________

☐ Weight loss surgery: *(date)*_________________________

____
____
____

SOCIAL HISTORY *(check all that apply)*

☐ Alcohol use: _____ drinks per week ☐ No Alcohol use

☐ At risk for HIV infection
(unprotected sex, IV drug use, history of blood transfusions)

☐ History of drug use

Smoking Status: ☐ Current If current: _____ packs per day
☐ Former (when quit: _________)
☐ Never smoked

Second hand smoke exposure:
☐ Environmental ☐ Occupational ☐ Perinatal/before birth

☐ Tobacco use (other/chew): _______________________

Preferred Pharmacy:________________________________
(Name, City)

LIST ALLERGIES TO MEDICATIONS: ☐ No Known Allergies

____
____

LIST CURRENT MEDICATIONS & SUPPLEMENTS:
(use back of this form for more space)

Name	Dose	Frequency	Route (oral, injection, etc.)

MEDICAL HISTORY FORM...continued

Name:__________________________________ Date of Birth_____/_____/________

FAMILY HISTORY *(check if blood relatives have the following)*

DISEASE	RELATIONSHIP TO YOU
☐ Diabetes	_______________________
☐ Thyroid/Parathyroid disorders	_______________________
☐ Thyroid cancer	_______________________
☐ Other cancer	_______________________
☐ Heart disease	_______________________
☐ Bleeding tendency	_______________________

☐ None of the above

REVIEW OF SYSTEMS

CHECK ☐ ALL THAT APPLY (Problems you have had within the past 3 months)

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitation or heart racing
- ☐ Swelling in legs or feet

EAR NOSE THROAT
- ☐ Dizziness
- ☐ Hoarseness

ENDOCRINE
- ☐ Breast discharge
- ☐ Excessive thirst
- ☐ Heat or cold intolerance

EYES
- ☐ Double vision
- ☐ Loss of vision

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea or vomiting

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change

INTEGUMENTARY (Skin)
- ☐ Changes in hair or nails
- ☐ New stretch marks

MUSCULOSKELETAL
- ☐ Hip pain
- ☐ Muscle cramps

NEUROLOGIC
- ☐ Frequent headaches
- ☐ Numbness around mouth
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

RESPIRATORY
- ☐ Frequent cough
- ☐ Shortness of breath

☐ I have none of the above symptoms

I have reviewed the above and checked all symptoms which apply.

Patient/Representative Signature:______________________________ Today's Date:______________________