CENTRAL CAROLINA EAR, NOSE AND THROAT ASSOCIATES, PA CHART # _____

PATIENT INFORMATION

Name _____

Street Address_____City _____State____ Zip _____

Mailing Address (if different) _____City_____State____ Zip_____

Birthdate _____ Age ____ Sex _____ Race _____ Marital Status _____ Social Security # _____

Employer _____ Occupation _____

Primary Care Physician _____City/Phone # _____

Referring Physician _____ City/Phone # _____

Home Phone _____ OK to leave message? _____ Yes ____ No

Work Phone _____ OK To leave message? _____ Yes ____ No

Cell Phone _____ OK to leave message? _____ Yes ____ No

Email address_____

How did you hear about our office?___ Physician Referral ___ Friend/Family ___ Newspaper ___ Facebook
___ Website ___ Enrichment Center Kiosk ___ Phone book Yellow Pages ___ Internet search ___Other

Responsible Party
(If patient is a minor, the responsible party is the person bringing in the patient)

Name _____ Relationship _____

Address (if different than above) _____

City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell phone _____

Birthdate _____ Social Security # _____

Employer _____

Emergency Contacts
(Can we discuss your medical condition with the person named below, mark yes or no)

Name _____ Relationship _____ Phone #_____ Yes/No

Name _____Relationship _____Phone# _____Yes/No

IMPORTANT NOTICE REGARDING USE OF ENDOSCOPE

Dr Lin and Dr Alexander feel that a patient presenting to our office with sinus, allergy, throat or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless, and in many cases, can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. In most cases we will accept your insurance company's allowance for this procedure. You will be obligated to pay only any deductible and/or copayments that are applied to this claim. (Please note, some insurance companies may list this diagnostic procedure as "surgery" on the insurance remittance advice you receive.)

These procedures have almost no risk and provide your physician with an excellent view of the areas involved. Please sign below to acknowledge that you have read the above and agree to undergo this procedure if needed.

IMPORTANT NOTICE REGARDING DIAGNOSTIC TESTING

Our doctors frequently order medically necessary tests that are performed outside of our office. This includes lab tests, allergy testing, CT's, MRI's, ultrasounds, etc. It is the **patient's** responsibility to make sure these services are covered by their insurance company. You can obtain this information by calling the phone number located on your insurance card. At the time of your call, you may want to check benefits for this test(s) to see if you must meet a deductible, have a copayment, etc.

Our staff will obtain precertification if it is required by your insurance company. You will be notified prior to your appointment if there is a problem with the precertification.

CANCELLATION POLICY: I understand that if I do not call 24 hours in advance to cancel a scheduled appointment, my account will be charged a $75 NO SHOW fee. This fee will have to be paid prior to scheduling another appointment with our office.

I have read and acknowledge CCENT's Notice of Privacy Practices.

I authorize CCENT to release information including the diagnosis and records of any treatments or examinations rendered to me or my child to my insurance company as necessary to carry out treatment, payment and healthcare operations. I also authorize and request my insurance company to make payment of any medical benefits directly to the CCENT.

I have read and agree to abide by the above and give my consent for treatment.

Patient/Parent/Guardian Signature:_____ Date _____

Central Carolina ENT Associates PA Chart # _____

Patient History Information

Name: _____ Date: _____

Pharmacy _____ Pharmacy address _____ City: _____

What is the reason for your visit today? _____

How long has the present problem been? _____

What treatments have you had? _____

Please list any allergies to medications: _____

_____

Please list all medications, including aspirin, over the counter medications, birth control:

_____

_____

_____

Past Medical History: Have you ever been treated for the following medical conditions **IN THE PAST**? **Check yes or no and then circle all that apply.** You may add additional information if necessary.

☐ Yes ☐ No CV Hx: angina, arrhythmia, cath, cardiac disease, heart failure, murmur, heart attack, pacemaker

☐ Yes ☐ No High Blood Pressure _____

☐ Yes ☐ No Skin Diseases (eczema, psoriasis, acne) _____

☐ Yes ☐ No Endocrine Hx: Diabetes, Thyroid Disease (hypo, hyper, Graves Disease)

☐ Yes ☐ No Gastrointestinal Disease (reflux, ulcers, intestinal, hepatitis, cirrhosis) _____

☐ Yes ☐ No Genito-urinary Disease (dialysis, kidney stones) _____

☐ Yes ☐ No HEENT: Allergies (seasonal), cholesteatoma, Meniere's _____

☐ Yes ☐ No Heme: Blood Diseases (anemia, bleeding problems) _____

☐ Yes ☐ No Imm: Cancer (list type or location & date) _____ Chemo___ Radiation_____

☐ Yes ☐ No Infections (TB, syphilis, HIV) _____

☐ Yes ☐ No Musculoskeletal: Arthritis (rheumatoid, osteo-degenerative), fibromyalgia, TMJ

☐ Yes ☐ No Neurological problems (strokes, seizures, headache, vertigo) _____

☐ Yes ☐ No Mental Health (depression, anxiety, bipolar) _____

☐ Yes ☐ No Respiratory Disease (asthma, bronchitis, COPD, emphysema, pneumonia, sleep apnea) _____

☐ Yes ☐ No use CPAP

☐ Yes ☐ No Other problems: _____

Previous Surgery (date/type) _____

_____

Previous ENT Surgery/Date (tonsils, ear tubes, throat, neck or sinus surgery, etc.) _____

_____

Social History:

Do you smoke tobacco? ☐ Yes ☐ No If yes, ___packs per day x ___years.

Have you ever smoked? ☐ Yes ☐ No If yes, ___packs per day x ___years. Quit ___y ago

Do you smoke cigars? ☐ Yes ☐ No Quit ___y ago

Do you chew tobacco? ☐ Yes ☐ No Quit ___y ago

Do you drink alcohol? ☐ Yes ☐ No If yes, occasional, moderate or heavy. Quit___y ago

Other drug use _____

Are you pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No LMP_____

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SEE OTHER SIDE

Family History: Do you have a family history of disease? Please list the relative.

☐ Yes☐ No Allergies_____
☐ Yes☐ No Anesthesia problems_____
☐ Yes☐ No Bleeding Disorder_____
☐ Yes☐ No Cancer_____
☐ Yes☐ No Diabetes_____
☐ Yes☐ No Hearing Loss_____
☐ Yes☐ No Heart Disease: heart attack_____Hypertension_____

Review of Systems: Do you <u>CURRENTLY</u> have any of the following problems? Check yes or no then circle all that apply:

☐ Yes☐ No HEENT: bloody nasal discharge, burning sensation in mouth, change in voice, cough, difficulty hearing, difficulty swallowing, ear drainage, ear infection, ear pain, facial fractures, facial swelling, jaw pain, loss of sense of smell or taste, lumps in mouth and neck, mouth bleeding, post-nasal drip, ringing in ears, runny nose, sinus problems, sore throat
☐ Yes☐ No Allergies: animals, seasonal, itchy eyes, itchy nose, sneezing
☐ Yes☐ No Respiratory: asthma, difficulty breathing, daytime sleepiness, coughing up blood, difficulty sleeping, shortness of breath, sleep apnea, snoring, wheezing
☐ Yes☐ No CV: chest pain, edema, elevated BP, heart attack, heart palpitation, irregular heartbeat, pacemaker, shortness of breath with exercise
☐ Yes☐ No Constitutional: fever, night sweats, tiredness, weight loss
☐ Yes☐ No Endocrine: high/low blood sugar, thyroid disease
☐ Yes☐ No Eye problems: abrupt visual loss, dry eyes, itchy eyes, excess tearing, swelling around eyes, red eyes, visual disturbance, double vision
☐ Yes☐ No GI: abdominal pain, diarrhea, difficulty swallowing, heartburn
☐ Yes☐ No GU: blood in urine, painful urination
☐ Yes☐ No Musculoskeletal: Joint Pain
☐ Yes☐ No Neuro: balance problems, headache, migraines, seizures, stroke, vertigo
☐ Yes☐ No Mental Health: anxious feelings, depression
☐ Yes☐ No Derm: dry scaly skin, facial rash, hypertrophic scars, non-healing wound
☐ Yes☐ No Heme: anemia, bleeding problems, bruise easily, clots in vein or lungs
☐ Yes☐ No Cosmetic Concerns: facial skin care, Botox, Restylane, other procedures

_____ _____
Signature Relationship to Patient

4/27/09