INDEPENDENCE
EAR, NOSE, & THROAT

PATIENT INFORMATION

02/2024

Welcome to Independence Ear, Nose & Throat

Patient's Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: □ M □ F

Primary Mailing Address:		
City:	State:	Zip

Alternate Street Address/Northern Address:		
City:	State:	Zip:

Race:	Language Spoken: □ English □ Spanish □ Other	Religion:	Ethnicity: □ Non-Hispanic / Non-Latino □ Hispanic / Latino
Marital Status: □ Single □ Married □ Domestic Partner □ Divorced □ Widowed		Student: □ Yes □ No Smoker: □ Yes □ No	Veteran: □ Yes □ No

What is your preferred method for appointment notifications? □ Text message □ Call – Cell Phone □ Call – Home Phone	Email Address:	
What is your preferred number for contacting you? □ Cell Phone □ Home Phone	Cell Phone Number:	Home Phone Number:

_____ I hereby authorize that Independence ear, Nose & Throat may text or leave a voicemail to confirm appointments and / or may
Initial speak with other members of my household and leave messages with them regarding my appointments.

EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone Number:	

Continued on the next page

INDEPENDENCE EAR, NOSE, & THROAT

PATIENT INFORMATION (continued)

02/2024

Patient Name: _____ Date of Birth: _____

Primary Care Doctor:	Phone Number:	City:
Referring Doctor:	Phone Number:	City:
Pharmacy:	Phone Number:	City:

Do you live in an Assisted Living Facility? □ Yes □ No	If yes, name of facility:
Do you live in a Nursing Home? □ Yes □ No	If yes, name of facility:

IF PATIENT IS A MINOR, PLEASE DESIGNATE PRIMARY CONTACT AUTHORIZED TO MAKE MEDICAL DECISIONS:		
Parent's or Legal Guardian's Last Name:	Parent's or Legal Guardian's First Name:	
Relationship to Patient:		
Primary Street Address:		
City:	State:	Zip
Race:	Language Spoken: □ English □ Spanish □ Other -	Ethnicity: □ Non-Hispanic / Non-Latino □ Hispanic / Latino
Preferred Method of Contact: □ Cell Phone □ Email □ Home Phone	Email Address:	
Home Phone:	Cell Phone:	

PRIMARY INSURANCE □ None **Patient Insurance Information:**		
Insurance Company:	Policy Number:	Group Number:
Primary Insured Name:	Relationship to Patient and Date of Birth:	
If Primary Insured is NOT the Patient:		
Primary Insured First Name:	Last Name:	Date of Birth:

INDEPENDENCE EAR, NOSE, & THROAT

Acknowledgement of Office Policies

02/2024

I acknowledge that I have received a copy of the following:

- Financial Policy Disclosure for Office Visits
- Patient Assignment of Benefits
- Consent to Electronic Statements
- Notice of In-Office Procedure Billing Policy
- Acknowledgement of Receipt of HIPAA Consent Form
- Medical Appointment Cancellation/No Show Policy

I have read and understood these policies and have been given the chance to ask any questions pertaining to these documents and policies. I have been given a copy of these policies to take home and keep for my reference.

By signing below, I state that I have read and understand these policies and agree with them. I understand that Independence Ear, Nose and Throat has the right to refuse service if refuse to sign.

Patient Name:	Date of Birth:	Date:
Signature:	Witness Signature:	

INDEPENDENCE EAR, NOSE, & THROAT

PATIENT HISTORY & PHYSICAL

02/2024

Name:	**Date of Birth:**
Reason for today's visit:	
Marital Status: Single Married Divorced Widowed	**Do you drink alcohol?** Yes:____ No:____ If yes, how many drinks per week? _____

Tobacco Use	YES	NO	QUIT	
Cigarettes	□	□	□	____packs per day for _____years
Cigars	□	□	□	____packs per day for _____years
Chew	□	□	□	

ANY DRUG ALLERGIES?

YES □ NO □

If yes, list name of drug & describe your reaction: _____

List all medications you are currently taking:

Name	dose	frequency

Have you recently experienced any of the following (circle all that apply):

Fever
Weight loss
Weight gain
Double vision
Dry eyes
Chest pain
Palpitations
Passed out
Short of breath
Wheezing
Nausea
Vomiting
Diarrhea
Headache
Seizure
Hair loss
Heat intolerance
Cold intolerance
Anxiety
Depression
Pain with urination Blood in urine Anemia
Easy bruising
Easy bleeding

INDEPENDENCE EAR, NOSE, & THROAT

PATIENT HISTORY & PHYSICAL

02/2024

Patient Name: _____ Date of Birth: _____

Have you experienced any of these medical problems in the past? (Circle all that apply)

Eczema	High Blood Pressure
Psoriasis	High Cholesterol
Glaucoma	High Lipids
Retina disease	Heart Attack
	Angina
Stroke	A Fib
TIA	Arrythmia
Seizure	Leg Clots
MS	Pulmonary Embolus
Alzheimer's	
Parkinson's	COPD
Migraine	Emphysema Chronic
Bell's Palsy	Bronchitis
	Pneumonia Asthma
Reflux (GERD)	TB
Gastritis Stomach	
Ulcer Hepatitis	Diabetes
Pancreatitis Colitis	Thyroid Disease
Diverticulitis	
	Gout
Arthritis Lupus	Osteoporosis
Sjogren's	Back Pain
HIV	
	Enlarged Prostate
Cancer* (if yes, please provide details below)	Endometriosis
	Kidney Stones
	Kidney Failure
	Depression
	Anxiety

Please give details of any other significant past medical history:

_____

_____

_____

_____

_____

_____

_____

INDEPENDENCE ENT EAR, NOSE, & THROAT

PATIENT HISTORY & PHYSICAL

Previous Surgery & Family History

02/2024

Patient Name: _____ Date of Birth: _____

Have you had any of the following procedures (circle all that apply):

	Add details		Add details
Skin cancer removal		Brain surgery	
Cataract surgery		Cervical spine surgery	
Glaucoma surgery		Lower back surgery	
Tear duct surgery		Knee surgery	
Breast augmentation		Carpel tunnel	
Breast reduction		Hip replacement	
Breast biopsy		Ear tubes	
Mastectomy		Ear drum repair	
C-section		Mastoidectomy	
Hysterectomy		Hearing bone repair	
Tubal ligation		Vocal cord surgery	
Ovary removal		Sleep apnea surgery	
Prostate surgery		Rhinoplasty	
Coronary bypass		Septoplasty	
Pacemaker		Turbinate surgery	
Heart stint		Sinus surgery	
Heart valve surgery		Neck mass excision	
Carotid surgery		Thyroidectomy	
Leg artery surgery		Parathyroidectomy	
Gallbladder removal		Tracheostomy	
Appendix removal		Parotid gland excision	
Colon resection		Submandibular gland excision	
Hernia repair			

Other: _____

_____

_____

FAMILY HISTORY

	YES	Which Relative(s)?
Asthma		
Bleeding Disorder		
Cancer		
Diabetes		
Heart Disease		
Thyroid Disease		