Date: _____ Reason for visit: _____

Patient Name: _____
Legal First MI Last

Sex: ☐ Male ☐ Female DOB: ____/____/____

Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Language: _____

Primary Care Provider: _____ Referring Provider (if different): _____

Pharmacy Preference (name & location) _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? ☐ Yes ☐ No If Yes, Please list below:

Name of Medication/Food	Type of Reaction

SURGERIES/HOSPITALIZATIONS

Have you had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No

If Yes, Explain: _____

List any surgeries (include dates): _____

_____

Have you been hospitalized for non-surgical reasons? ☐ Yes ☐ No If Yes, Explain: _____

_____

Do you smoke? ☐ Yes ☐ No ☐ Former

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

If you are 65 yrs old or older, have you had pneumonia vaccine? ☐ Yes ☐ No If Yes, Date: _____

Name: _____

DOB: _____

CONSENTS

1) I give consent for Ear, Nose & Throat Surgeons of Western New England, LLC to obtain my prescription history from my health plan or pharmacy. ☐ Yes ☐ No

2) I authorize Ear, Nose & Throat Surgeons of Western New England, LLC to disclose my Protected Health Information to the following friends or family members:

_____

Name Relationship Telephone #

_____

Name Relationship Telephone #

3) My preference contact method is:

☐ Phone: Cell / Home # _____

☐ Text: #_____

☐ Email: _____

Initials _____

PAYMENT POLICY

4) Payment is expected at the time of service. Failure to pay co-payment, co-insurance, deductible or any outstanding debt will result in a $10 processing fee per incident. Failure to pay may lead to discharge from the practice.

Initials _____

NO SHOW POLICY

5) If you cannot keep your scheduled appointment, please call 24 hours in advance to avoid no show office charges. We reserve the right to charge $30 for missed appointments. If you repeatedly "No Show" and/or cancel your appointments, we reserve the right to discharge you from care.

Initials _____

Patient/Parent Signature: _____

Date: _____