SACRAMENTO
EAR | NOSE | THROAT
FACIAL PLASTIC SURGERY

Doctor: _____

Acct: _____

Date: _____

Please print neatly and fill out every item as accurately as possible. Ask a staff member if you require assistance in filling out this form.

Name: _____ _____ _____
First **Middle** **Last**

Date of Birth: _____ ☐ **Male** ☐ **Female** **SSN** _____-_____-_____
mm/dd/yyyy

Address:_____
Street **City** **State** **Zip**

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Employer: _____ **Work Phone:** (_____) _____

Email: _____ **Preferred Language:** _____

Emergency contact: _____ _____ (_____) _____
Name **Relationship** **Phone**

Race: _____ **Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Other: _____

Primary Insurance Information	**Secondary Insurance Information**
Insurance Name:	**Insurance Name:**
Insurance ID :	**Insurance ID :**
Group or Policy Number:	**Group or Policy Number:**
Policy Holders Name:	**Policy Holders Name:**
Policy Holders Relationship to Patient:	**Policy Holders Relationship to Patient:**
Policy Holders SSN: Date of Birth:	**Policy Holders SSN: Date of Birth:**

Primary Care Physician (Family Doctor) _____

Referring Physician_____

Medicare/Medi-Cal Lifetime Signature on File*:*
I request that payment of authorized Medicare/Medi-Cal benefits be made on my behalf to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Signature **Date**

ADULT

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What is the reason for your visit today? _____

List all current medications, including any over the counter (OTC) medications or Supplements ☐ **Not taking any medications**

Name of Medication and Dosage

List any drug allergies or medicines you cannot take ☐ **No known drug allergies**

Name of Medication	Type of Reaction

Pharmacy: Name _____ Address: _____

Phone #: _____ Fax #: _____

Non- Medication Allergies

Have you ever had allergy testing?

☐ **No**
☐ **Yes When: _____**

Have you ever taken allergy shots? ☐ **No** ☐ **Yes**
Are you currently taking shots? ☐ **No** ☐ **Yes**

Are you allergic to any of the following?

☐ **Latex** ☐ **Tape** ☐ **Foods _____**
☐ **Other _____**

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Past Health History

Please indicate any diseases that you have had or been diagnosed with by a doctor

☐ **No Major Illnesses**

Childhood Diseases
☐ Chicken Pox
☐ Measles
☐ Mumps
☐ Other_____

Ears, Nose & Throat
☐ Ear Infections
☐ Hearing Loss
☐ Sinus Infections
☐ Sleep Apnea
☐ TMJ Dysfunction
☐ Other _____

Digestive
☐ Diverticulitis
☐ Hemorrhoids
☐ Hepatitis – Type: A B C
☐ Irritable Bowel Syndrome
☐ Reflux
☐ Gallbladder Disease (Stones)
☐ Other _____

Brain/Nervous System
☐ Alzheimer's/Dementia
☐ Seizures
☐ Multiple Sclerosis
☐ Stroke
☐ Headache
☐ Other _____

Cancer
☐ Breast
☐ Leukemia
☐ Lung
☐ Other _____

Heart
☐ Angina (chest pain)
☐ Heart Attack
☐ Hypertension
☐ Murmur
☐ Mitral Valve Prolapse
☐ Other _____

Bones/Joints
Arthritis: ☐ Osteo ☐ Rheumatoid
☐ Osteoporosis
☐ Other_____

Mental/Emotional Health
☐ Anxiety Disorder
☐ Bi-Polar
☐ Depression
☐ Other _____

Allergies/Immune System
☐ AIDS/HIV
☐ Autoimmune disorder
☐ Lupus
☐ Other _____

Congenital (Birth) Problems
☐ Congenital Malformation
☐ Down's Syndrome
☐ Prematurity
☐ Other_____

Lungs
☐ Asthma
☐ COPD
☐ Cystic Fibrosis
☐ Tuberculosis
☐ Other _____

Skin
☐ Rosacea
☐ Acne
☐ Eczema
☐ Psoriasis
☐ Other _____

Glands/Hormones
Diabetes: ☐ Type I ☐ Type II
☐ Grave's Disease
Thyroid Disease:
☐ Hyper ☐ Hypo

History of any Other Condition:
☐ _____
_____

Female Patients: Are you pregnant? ☐ Yes ☐ No ☐ Possibly / Not Sure

Surgeries

Have you ever had problems with anesthesia (being put to sleep for surgery)? _____
(Please describe)

Please indicate any ENT surgeries you have had: ■ **No Surgery**

Ears	☐ Ear Tubes	☐ Other		
Nose	☐ Rhinoplasty	☐ Septoplasty	☐ Sinus	☐ Other
Mouth /Neck	☐ Tonsil / Adenoid	☐ Thyroid Total or Partial?		☐ Other

Please list any other major surgeries:
_____
_____
_____

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Have you ever had a serious injury? ☐ **No** ☐ **Yes** _____
(Please describe)

Tests & Immunizations

Please supply dates for all screenings and vaccinations

Pneumonia Vaccine: ___/____/_____ **Flu Vaccine:** ____ /____/_____
Colonoscopy: _____/____/_____ **Mammogram:** ____/____/_____
PAP smear: _____/____/_____ **Bone Density Screening:** _____/_____/_____

Family History

Please list any of your BLOOD RELATIVES who have a history of any of the following and give their relationship to you:

☐ **Family history unknown**

			RELATIONSHIP
Problems/Complications with Anesthesia	☐ **No**	☐ **Yes**	_____
Heart Problems (Including Hypertension)	☐ **No**	☐ **Yes**	_____
Lungs	☐ **No**	☐ **Yes**	_____
Bleeding/Clotting Problems	☐ **No**	☐ **Yes**	_____
Glands/Hormones (Diabetes)	☐ **No**	☐ **Yes**	_____
Cancer	☐ **No**	☐ **Yes**	_____
			(Please describe who and type)
Other Major Health Problems	☐ **No**	☐ **Yes**	_____
			(Please describe)

Social History

Current Occupation: _____ ☐ **Disabled** ☐ **Retired** ☐ **Student**

Marital status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Cohabitating**

Current tobacco use?

☐ **Never** ☐ **Yes:** ☐ **Cigarette** ☐ **Cigar** ☐ **Pipe** ☐ **Chew**

When did you start? Age: _____or Year: _____ **Average use per day** _____

☐ **Quit**

When did you stop? Age: _____or Year: _____

Alcohol use? ☐ **No** ☐ **Yes**

Types & average number per week? **Beer: ____ Wine: ____ Wine Coolers: ____**
Mixed Drinks or Liquor ____

Have you ever been dependent on or addicted to any drugs?
☐ **No**
☐ **Yes** _____ ☐ **Prefer to discuss with doctor**
(Please describe)

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Please answer yes or no to any other SYMPTOMS that you have now or have had RECENTLY

		General:			**Stomach/GI Problems**
☐ No	☐ Yes	Fever	☐ No	☐ Yes	Abdominal Pain
	☐ Yes	Weight loss		☐ Yes	Constipation/Diarrhea
		☐ Planned ☐ Unintentional		☐ Yes	Excessive Gas
	☐ Yes	Weight gain		☐ Yes	Heartburn/Indigestion
	☐ Yes	Sleeping Problems		☐ Yes	Other:_____
	☐ Yes	Other: _____			*(Please describe)*
		(Please describe)			**Urinary or Female/Male Problems**
		Eye Problems:	☐ No	☐ Yes	Difficulty Starting/Stopping Stream
☐ No	☐ Yes	Blurred vision		☐ Yes	Frequency/Urgency
	☐ Yes	Double vision		☐ Yes	Incontinence
	☐ Yes	Itching/Burning		☐ Yes	Pain/Bleeding
	☐ Yes	Other:_____		☐ Yes	Other:_____
	☐ Yes	*(Please describe)*			*(Please Describe)*
					Bone/Muscle problems:
		Ear Problems:	☐ No	☐ Yes	Painful Joints
☐ No	☐ Yes	Dizziness		☐ Yes	Pain/Stiffness in Neck
	☐ Yes	Drainage		☐ Yes	Weakness
	☐ Yes	Hearing Loss			Other:_____
	☐ Yes	Infection			*(Please Describe)*
	☐ Yes	Itching			**Breast or Skin problems:**
	☐ Yes	Pain	☐ No	☐ Yes	Change in Moles
	☐ Yes	Ringing		☐ Yes	Dry/Itchy Skin
	☐ Yes	Other:_____		☐ Yes	Rash
		(Please describe)		☐ Yes	Sores
		Nose Problems:		☐ Yes	Other:_____
☐ No	☐ Yes	Nasal Congestion			*(Please describe)*
	☐ Yes	Itching			**Brain or Nerve Problems:**
	☐ Yes	Nosebleeds	☐ No	☐ Yes	Change in smell
	☐ Yes	Postnasal Drainage		☐ Yes	Change in taste
	☐ Yes	Other:_____		☐ Yes	Change in Vision NOT Corrected with Glasses
		(Please describe)			
		Mouth Problems:		☐ Yes	Memory Loss
☐ No	☐ Yes	Bad Breath		☐ Yes	Headache
	☐ Yes	Dryness		☐ Yes	Numbness
	☐ Yes	Hoarseness or Other Voice Change		☐ Yes	Facial Pain
	☐ Yes	Snoring		☐ Yes	Weakness
	☐ Yes	Sore Throat		☐ Yes	Other:_____
	☐ Yes	Swallowing Difficulty			*(Please describe)*
	☐ Yes	Other:_____	☐ No	☐ Yes	**Blood or lymph problems:**
		(Please describe)		☐ Yes	Excessive Bleeding
		Heart Problems		☐ Yes	Easy bruisability
☐ No	☐ Yes	Lightheadedness		☐ Yes	Neck Mass/Swelling
	☐ Yes	Chest Pain			Other:_____
	☐ Yes	Irregular Heartbeat/Palpitations			*(Please describe)*
	☐ Yes	Other:_____	☐ No	☐ Yes	**Immune Problems:**
		(Please describe)		☐ Yes	Hives
		Lung Problems:		☐ Yes	Unusual Infections
☐ No	☐ Yes	Frequent Cough		☐ Yes	Other:_____
	☐ Yes	Difficulty Breathing/Short of Breath			*(Please describe)*
	☐ Yes	Other:_____	☐ No	☐ Yes	**Other medical problem not listed:**
		(Please describe			_____
					_____
					(Please describe)

ADULT