

# SACRAMENTO

SACRAMENTO EAR NOSE AND THROAT SURGICAL AND MEDICAL GROUP

**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.

Doctor: \_\_\_\_\_ Acct: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Information**

**Guarantor/Responsible Party information**

Child's Name: First, Middle, Last		Guarantor/Responsible Party Name: First, Middle, Last	
Child's Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (including zip):		Address: <input type="checkbox"/> Same as child	
Home Phone: ( )		Cell Phone: ( )	
Emergency Contact Name:		Employer:	Work Phone ( )
Relationship:		Address:	
Phone: ( )		Relationship to Patient: (for other please specify relationship) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other	

Email: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

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 Date of Birth:	Policy Holders 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 the patient's behalf to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. for any services furnished the patient by the physician. I authorize any holder of medical information about the patient 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 the patient 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 the patient. This information will be used for the purpose of evaluating and administering claims of benefits. . I also understand that in the event I have no insurance coverage, I am responsible for all billed charges.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date

What is the reason for your child's visit today? \_\_\_\_\_

How tall is your child? \_\_\_\_\_

How much does your child weigh? \_\_\_\_\_

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 your child can not take

No known drug allergies

Name of Medication	Type of Reaction

Has your child ever had allergy testing?

- No
- Yes

Has your child ever taken allergy shots?

- No  Yes

Is your child currently taking shots?

- No  Yes

Is your child allergic to any of the following?

- Latex  Tape  Foods \_\_\_\_\_
- Other \_\_\_\_\_

**Tests & Immunizations**

Pneumonia Vaccine:  No  Yes: Date administered: \_\_\_\_\_

Pharmacy: Name \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

## Past Health History

*Please indicate any diseases or problems that your child has had or been diagnosed with by a doctor*

No Major Illnesses

### Childhood Diseases

- Chicken Pox
- Measles
- Mumps
- Other \_\_\_\_\_

### Congenital (Birth) Problems

- Congenital Malformation
- Down's Syndrome
- Prematurity (# of weeks \_\_\_\_\_)
- Cystic Fibrosis
- Other \_\_\_\_\_

### Other Problems

- Acne
- Asthma
- Diabetes
- GERD/Reflux
- Sleep Apnea
- Other \_\_\_\_\_

*History of any other condition not listed?* \_\_\_\_\_

(For Teenage Female Patients) *Are you pregnant?*     Yes     No     Possibly / Not Sure

*Has your child had surgery?*     No     Yes \_\_\_\_\_  
(Please describe)

*Serious injury?*     No     Yes \_\_\_\_\_  
(Please describe)

## 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

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	RELATIONSHIP
Problems/Complications with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems (Including Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands/Hormones (Diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe)
Other Major Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe)

## Social History

*Is your child currently attending school?*     Yes     No    *What grade level?* \_\_\_\_\_

*Does your child use tobacco?*     Never     Quit     Yes

*Does your child use any other drugs?*     No     Not Sure     Yes \_\_\_\_\_  
(Please describe)

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

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