Lake Breeze ENT & Allergy

Patient Name					
Date of Birth	Age	Gender	Race	Ethnicity	Language

Street Address	City, State, Zip
Primary Phone #	Cell Phone #

School/Employer	Work Phone #	Social Security #
EMERGENCY CONTACT INFORMATION	*Please List Name of Contact*	Relationship: Phone Number:

**NAME AND LOCATION OF THE PRIMARY PHARMACY YOU USE: Pharmacy Phone #

FOR PATIENTS UNDER 18 YEARS, PLEASE COMPLETE PARENTS'/GUARDIAN INFORMATION

Responsible Party Name

Relationship to the Patient
□Mother □Father □Step-Parent □ Legal Guardian

Address

Home Phone	Cell Phone
Date of Birth	Marital Status M D S W

Employer

Length of Employment	Work Phone #	Social Security Number

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY FOR OUR FILES

Name of Primary Insurance Co.

Insurance Co. Address

Insurance Co. Phone #

Name of Policy Holder

Relationship to Patient
□Self □Mother □Father □Step-Parent □Legal Guardian

Policy Holder Social Security #

Policy Holder Date of Birth

(USE THIS PORTION ONLY IF YOU HAVE A SECONDARY INSURANCE POLICY)

Name of Secondary Insurance Co.

Name of Policy Holder

Insurance Co. Address

Insurance Co. Phone #

Policy Holder ID

Policy Holder Social Security #

Relationship to Patient
□ Mother □Father □Step-Parent □Spouse □ Self □Other

The above information is correct to the best of my knowledge. It is my responsibility to inform you of any changes. I authorize the doctor, nurses and staff to perform any necessary service that I/my child may need during diagnosis and treatment with my informed consent.
I understand that I am responsible for payment of services rendered. Lake Breeze ENT & Allergy will submit all applicable insurance claims on my behalf. I understand and give permission to Lake Breeze ENT & Allergy to accept payment from my insurance company. I also understand that any remaining amount due after my insurance has processed (paid/denied), will be my responsibility.

Signature	Relationship to Patient	Date
X	□Mother □Father □Step-Parent □Self □Other	X

How did you hear about us?

- ○ Friend Referral: _____
- ○ Family Referral: _____
- ○ Dr. Referral _____
- ○ Online Search engine_____
- ○ Insurance carrier's list_____
- ○ Hospital System's "Find a Doc"_____
- ○ Magazine advertisement_____
- ○ Newspaper Advertisement_____
- ○ Facebook
- ○ Website
- ○ Mailer
- ○ Other: _____

Do you have trouble understanding conversations when you are in a noisy environment?

- ○ Yes
- ○ No
- ○ Sometimes

Do you Experience noises in your ears?

- ○ Yes
- ○ No
- ○ Sometimes

Do you have nasal congestion or stuffiness?

- ○ Yes
- ○ No
- ○ Sometimes

Do you cough or clear your throat?

- ○ Yes
- ○ No
- ○ Sometimes

Are you frequently tired even after a full night's sleep?

- ○ Yes
- ○ No
- ○ sometimes

Lake Breeze
ENT & Allergy

Confidential Patient Health History

Patient Name: _____ **DOB:** _____

Referring Physician Name: _____

Primary Care Physician Name: _____

Reason for your visit today:

_____

_____

Please list your current medications (include over the counter medications or supplements)

_____

_____

_____

Medical History: Do you have now or have you had any of the following (Please check)

□Heart Trouble	□Asthma	□Thyroid problems
□High blood Pressure	□Chronic lung disease	□Kidney disease
□Rheumatic Fever	□Tuberculosis	□Drug Addiction
□Prolonged Bleeding	□Chest Pain	□Anemia
□Blood Disorder	□Alcoholism	□Cancer
□Diabetes	□Psychiatric treatment	□Eye disease
□Stroke	□Arthritis	□Epilepsy
□Jaundice	□Blood Transfusion	□Liver problems
	□Hepatitis	

(Women) Are you pregnant now or do you think you may be pregnant? □ Yes □ No

Other medical history or problems not listed:

_____

_____

Allergies: List any Drug allergies and reactions:

Drug	Reaction
Drug	Reaction
Drug	Reaction
Drug	Reaction

List any surgeries you have had (include dates):

_____

_____

List any previous hospitalizations (include dates):

_____

_____

Do you smoke or use tobacco products? □ Yes □ No **How long?** _____

If so what form and how much? _____

Does anyone else in your household smoke or use tobacco products? □ Yes □ No

Do you drink alcohol? □Yes □No **How much and how often?** _____

Do you feel like you may be at risk for AIDS? □Yes □No

(Health History continued on next page)

(Confidential Patient Health History cont.)

Family History: Is there any pertinent family history that we need to know about?

Mother: _____

Father: _____

Grandparent: _____

Aunts: _____

Uncles: _____

Other: _____

_____

Recently have you experienced any of the following: Please circle Yes or No

Chills	Yes	No
Fever	Yes	No
Night Sweats	Yes	No
Double Vision	Yes	No
Blurred Vision	Yes	No
Diminished Vision	Yes	No
Excessive Thirst	Yes	No
Frequent Urination	Yes	No
Shortness of Breath at Rest	Yes	No
Shortness of Breath with Exertion	Yes	No
Wheezing	Yes	No
Chest Pain with Exertion	Yes	No
Difficulty Lying Flat	Yes	No
Change in Bowel Habits	Yes	No
Difficulty Swallowing	Yes	No
Weight Loss	Yes	No
Blood in urine	Yes	No
Painful Joints	Yes	No
New Moles or Lesions	Yes	No
Eczema	Yes	No
Itching	Yes	No
Gait Abnormality	Yes	No
Headache	Yes	No
Depressed Mood	Yes	No
Difficulty Sleeping	Yes	No

Please list any other important information you think we should know about:

_____

_____

Lake Breeze ENT & Allergy

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name: _____ Date of Birth: _____

Print Parent /Guardian Name: _____

Relationship to Patient: □Mother □Father □Step-Parent □Self □Other(Specify)_____

Do you want to give authorization for anyone other than yourself to have access to the above patient's medical and/or financial information? □ YES □ NO

If **YES please list to whom you would like information to be released and how:

□ Voice Mail □ E-Mail	□Financial □Medical	(List E-Mail and /or Phone #)	
□ Spouse	□Financial □Medical	(List Name and DOB with Phone #)	
□ Parent	□Financial □Medical	(List Name and DOB with Phone #)	
□ Other	□Financial □Medical	(List Name and DOB with Phone #)	

I authorized Lake Breeze ENT & Allergy to access my prescription history from the past year to assist in avoidance of prescription interactions.

X_____ **X**_____

Signature of Patient/Parent/Guardian or Personal Representative *Date*

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where this information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will be in effect until revoked by the patient or the parent/guardian if patient is a minor.

I acknowledge that I have received a copy of the Notice of Privacy Policy. A copy of this policy is also located in the waiting area of Lake Breeze ENT & Allergy and may be found on our website at: **www.lakebreezeent.com**

X_____ **X**_____

Signature of Patient/Parent/Guardian or Personal Representative *Date*

**Description of Personal Representative's Authority (Attach Necessary Documentation)*

*_____

Please list your e-mail address below if you would like to receive e-mails to link you to your Patient Portal where you can access information such as Medical History, Visit Summary, Medication, etc.

_____

You will receive an e-mail notification and will need to activate your account if you want to view your account information