Chesapeake Otolaryngology Associates, LLC

PATIENT HISTORY

PATIENT NAME: ______________________________ **DATE:** ____________________
Last Name First Name M.I.

REASON FOR TODAY'S VISIT: ______________________________

REFERRAL INFORMATION

How did you hear about us? ☐ Doctor ☐ Family Member/Friend ☐ Newspaper/Yellow Pages

☐ Website drgailanderson.com other website ____________ Other________________

Referring doctor's name: ______________________________

Primary care doctor's name: ______________________________

MEDICAL/SURGICAL HISTORY

Do you have, or have you ever had, any of the following:

High Blood Pressure	Yes	No	Stomach Ulcers/ Gastritis	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No
Heart Attack/ Stent	Yes	No	Liver Problems	Yes	No
Stroke	Yes	No	Lupus Erythematosis	Yes	No
Seizures	Yes	No	Sarcoidosis	Yes	No
Thyroid Problems	Yes	No	Multiple Sclerosis	Yes	No
Asthma	Yes	No	Rheumatoid Arthritis	Yes	No
TMJ Syndrome	Yes	No	Cancer	Yes	No

If yes, specify ____________________

Other: ______________________________

Please list any medications to which you are allergic and the type of reaction ____________________

____

Please list any medications you are currently taking (include herbal and OTC products) ______________

____

____

____

Please list any surgery and/or hospitalizations ______________________________

____

____

Are you pregnant? Yes No Date of anticipated delivery __________

Do you drink alcohol? Yes No If yes, how much? ______________________________

Do you or have you ever used tobacco? Yes No cigarettes cigars chewing tobacco Other

If yes, how much, how often, and for how long? ______________________________

When and how did you quit? ______________________________

Chesapeake Otolaryngology Associates, LLC

Patient Registration

Registration Date:________________________

Patient Name::____ __ Male __ Female
Last Name First Name M.I.

Date of Birth:______ Age:____ Marital Status: __ Single __ Married __ Widowed __ Divorced/Separated

Nickname: (if any):_____________ Maiden Name: ______________ Social Security #:________________

Home Address: ____
Street or P.O. Box City State County Zip Code
Mailing Address: (if different from above)____
Street or P.O. Box City State County Zip Code
Home Phone: ________________ Daytime Phone: ________________ Cell: _________________

Emergency Contact: _________________ Phone #:______________ Relation to Patient:_____________

Nearest relative not living with patient:____________ Phone#: __________Relation to Patient:_________

Patient's Employer

Employer: ____ Work Phone: _________________

Address: ____
Street or P.O. Box City State County Zip Code

Spouse or Guarantor (Person responsible for payment. Disregard if same as patient)

Name: ____ Relation to patient: ___________
Last Name First Name M.I.
Date of Birth: _____________________ Age: _______ Social Security#: ______________

Home Address: ____
Street or P.O. Box City State County Zip Code
Mailing Address: (if different from above)____
Street or P.O. Box City State County Zip Code

Spouse or Guarantor Employer:

Employer: ____ Work Phone: _________________

Address: ____
Street or P.O. Box City State County Zip Code

Pharmacy Information
Local Pharmacy: ____ Phone: _______________

Insurance Information

Primary Insurance

Insurance Name:___________________
Policy #__________________________
Group#___________________________
Policy Holder's Name_______________
Insurance Address:__________________
____
____

Secondary Insurance

Insurance Name:____________________________
Policy #___________________________________
Group #___________________________________
Policy Holder's Name________________________
Insurance Address:__________________________
____
____

Release of Information and Assignment

I hereby authorize you to release to my referring physician and/or family doctor any information including the diagnosis and records of any treatment or examination rendered to me.

I certify that the information I have reported with regard to my insurance coverage is correct. I hereby assign my insurance benefits to paid directly to Chesapeake Otolaryngology Associates, LLC for services rendered. I acknowledge that I am financially responsible for all non-covered services , deductibles, and copayments. I authorize Chesapeake Otolaryngology Associates, LLC to release any information required to process this claim.

This authorization may be revoked by either my insurance carrier or me at any time in writing. I understand that my insurance coverage is a contract between the insurance company and myself and that Chesapeake Otolaryngology Associates, LLC will submit claims on my behalf, but will not be responsible for filing appeals or disputing rejections. I authorize and understand that the physician's office will be billing electronically. A copy of this authorization may be used in place of the original.

I understand that I am responsible for all charges incurred regardless of my insurance status. Charges not paid within ninety (90) days by insurance companies will be made patient responsible. I further agree, in the event of default due to nonpayment, to be responsible for collection fees, court costs and/or legal fees and /or legal fees and that there will be a $25.00 fee for all returned checks.

______________________________________ ________________________________
Signature of Patient or Parent/Guardian Date

____
Relationship To Patient If Parent or Guardian

Chesapeake Otolaryngology Associates, LLC

Patient Name__________________________________ Date____________________
Last Name First Name M.I.

Please circle if you are experiencing or have experienced any
of the following in the past year:

Constitutional
Decreased Appetite
Fatigue
Fever
Night Sweats
Weight Gain/Loss

HEENT
Headaches
Eye Itching
Vision Changes

Hearing Loss
Noise Exposure
Ringing/ Noise in Ear

Nasal Discharge
Nosebleeds
Nasal Congestion
Sneezing

Voice Change
Difficulty Swallowing
Lump in Throat
Post Nasal Drip
Sore Tongue/ Throat
Snoring

Respiratory/ Cardiovascular
Cough
Shortness of Breath
Wheezing
Chest Pain

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Heartburn
Acid Reflux
Vomiting

Metabolic/Endocrine
Cold/Heat Intolerance
Frequent Thirst/ Hunger
Frequent Urination

Neuro/ Psychiatric
Dizziness/ Lightheadedness
Fainting
Difficulty with Speech
Memory Loss
Tremors
Anxiety
Depression
Irritability
Mood Swings

Dermatological
Skin Itching (Pruritis)
Skin Rash

Musculoskeletal/ Hematology
Joint/ Bone Pain
Easy Bruising
Easy Bleeding

Immunological
Environmental/ Seasonal Allergies
Food Allergies