
HEAD & NECK SURGICAL GROUP

PATIENT INFORMATION

Patient Name: _____ Soc. Sec. #: _____
Address: _____ City: _____
State: _____ Zip: _____ Date of Birth: _____ Age: _____
Sex: M F Marital Status: S M D W
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ E-Mail Address _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (____) _____

EMPLOYER

Name: _____
Address: _____

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN (to whom reports may be sent)

Name: _____ Phone: (____) _____
Address: _____

WHO REFERRED YOU TO THIS OFFICE?

Referring Physician Name: _____ Friend Name: _____
? HMO or Health Insurance Company ? Yellow Pages ? Website ? Other _____

INSURANCE INFORMATION

	#1	#2
Insurance Company	_____	_____
Address	_____	_____
City, State, Zip	_____	_____
Phone #	_____	_____
Policyholder Name	_____	_____
Insured's Birthdate, SS#	_____	_____
Relationship to Patient	_____	_____
Policy #, Group #	_____	_____
Co-Pay Amount	_____	_____

I have received a copy of the Head & Neck Surgical Group's Notice of Privacy Practices. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Credit cards or Debit Cards may be used, in addition to cash or check.

Date: _____ Patient Signature: _____

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ HEIGHT: _____ WEIGHT: _____

REVIEW OF SYSTEMS - CHECK ALL THAT APPLY:

<p>Head & Neck</p> <input type="checkbox"/> Eye Disease <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Prior Ear Surgery <input type="checkbox"/> Ear Ache <input type="checkbox"/> Hearing loss <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Nasal Obstruction <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Altered sense of smell <input type="checkbox"/> Sinusitis <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Snoring <input type="checkbox"/> Excessive sleepiness <input type="checkbox"/> Facial pain <input type="checkbox"/> Pain with chewing <input type="checkbox"/> Recent dental work <input type="checkbox"/> Mouth sores <input type="checkbox"/> Lumps in the neck <input type="checkbox"/> Allergies	<p>Respiratory System</p> <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chronic cough <input type="checkbox"/> Throat clearing <input type="checkbox"/> Heart Burn <input type="checkbox"/> Regurgitation <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Chest Pain <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Lung cancer <p>Neurologic</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Head injury <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Transient black-outs <input type="checkbox"/> Transient vision loss <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes	<p>General</p> <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fevers <input type="checkbox"/> Skin diseases <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Easy Bruisability <input type="checkbox"/> HIV infection or AIDS <input type="checkbox"/> Psychiatric Diseases <p>Gastrointestinal</p> <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> Pain on swallowing <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Bloody stools <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Gall bladder disease <input type="checkbox"/> Heartburn or ulcers	<p>Cardiovascular</p> <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease <input type="checkbox"/> Angina <input type="checkbox"/> Swelling of the ankles <input type="checkbox"/> Heart surgery <input type="checkbox"/> Angioplasty <input type="checkbox"/> Pacemaker <input type="checkbox"/> Anemia <p>Endocrine</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Thyroid imbalance <input type="checkbox"/> Menstrual disorders <p>Urologic</p> <input type="checkbox"/> Difficulty on urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Prostate problems <p>Other</p> <hr/>
--	--	--	--

<p>Past and present medical problems:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Previous surgeries and dates (month/year)</p> <p>_____ (/)</p> <p>_____ (/)</p> <p>_____ (/)</p> <p>_____ (/)</p> <p>_____ (/)</p>	<p>List all current medications and dosages (including OTC):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	--	--

<p>Do you smoke?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much?</p> <p>_____</p>	<p>Do you drink alcohol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much?</p> <p>_____</p>	<p>Any other information for Dr.?</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	---	---

Please list all allergies:
 (medications, inhalants, foods, contact allergies)

Reason for today's visit: _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____