PATIENT DEMOGRAPHICS

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

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other ☐ Ethnicity/Race: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Primary Phone #: _____ ☐ Home ☐ Cell

Secondary Phone #: _____ ☐ Home ☐ Cell

Appointment Reminders: ☐ Phone ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Spouse Name: _____ Spouse Phone: _____

If a Minor: Parent's Names: _____ Contact Phone: _____

Name of Stepparent(s): _____ Foster Parent: _____

Guardian's Name: _____ Guardianship Paperwork: ☐ Yes ☐ No

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____ Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Employer: _____ HR Contact Name & Phone #: _____

Complete the following if you are ***not*** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____ SS #: _____

Employer: _____ HR Contact Name & Phone #: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____ Group #: _____ ID #: _____

Secondary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Employer: _____ HR Contact Name & Phone #: _____

Complete the following if you are ***not*** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____ SS #: _____

Employer: _____ HR Contact Name & Phone #: _____

TREATING PHYSICIANS

Primary Care Physician: _____ Phone: _____

List all other active treating physicians:

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

MEDICATION ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

MEDICATION

List the medications you are currently taking, including the dosage:

Medication: _____ Dose: _____ ☐ See List
(Check box if you provided a list)

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

Relative	**Condition**	**Living?**	**If deceased, at what age?**
Mother	_____	☐ Y ☐ N	_____
Father	_____	☐ Y ☐ N	_____
Sibling	_____	☐ Y ☐ N	_____
Other:	_____	☐ Y ☐ N	_____
Other:	_____	☐ Y ☐ N	_____

SURGICAL HISTORY

List any surgeries, fractures, major illnesses or hospitalizations you have had:

Description	Doctor/Location	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Have you ever had any of the following?

Allergies	☐ Y ☐ N	Hearing Loss	☐ Y ☐ N
Anxiety	☐ Y ☐ N	Heart Burn	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Heart Disease	☐ Y ☐ N
Asthma	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N
Back Pain	☐ Y ☐ N	Hives	☐ Y ☐ N
Bleeding Problems	☐ Y ☐ N	Hoarseness	☐ Y ☐ N
Coronary Artery Disease	☐ Y ☐ N	Hyperlipidemia	☐ Y ☐ N
Cancer	☐ Y ☐ N	Hypothyroidism	☐ Y ☐ N
Cardiac Arrest	☐ Y ☐ N	Insomnia	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Joint Pain	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N
Congestion	☐ Y ☐ N	Migraines/Headaches	☐ Y ☐ N
Cough	☐ Y ☐ N	Neuropathy	☐ Y ☐ N
Depression	☐ Y ☐ N	Nose Bleeds	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Diarrhea	☐ Y ☐ N	Rash	☐ Y ☐ N
Dizziness/Balance Problems	☐ Y ☐ N	Seizure Disorder	☐ Y ☐ N
Drug/Alcohol Abuse	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N
Ear Infections	☐ Y ☐ N	Sinus Condition	☐ Y ☐ N
Fainting	☐ Y ☐ N	Skin Cancer	☐ Y ☐ N
Fatigue	☐ Y ☐ N	Stroke	☐ Y ☐ N
Food Allergies	☐ Y ☐ N	Urinary Problems	☐ Y ☐ N
Gerd	☐ Y ☐ N	Vision Loss	☐ Y ☐ N

List any other medical problems you have had: _____

_____

SOCIAL HISTORY

Do/did you consume alcohol? ☐ Yes ☐ No ☐ Quit

If yes, how many drinks do/did you have per week? _____ and/or quit date: _____

Do you currently smoke? ☐ Yes ☐ No If yes, start date: _____ and/or quit date _____

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do/did you smoke per day? _____

Do you currently use any other drugs? ☐ Yes ☐ No

- What other drugs do you take? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you drink or take caffeine? ☐ Yes ☐ No How much per day? _____

Complete the following if applicable:

Are you planning a pregnancy? ☐ Yes ☐ No Are you pregnant now? ☐ Yes ☐ No

ENT-RELATED MEDICAL HISTORY

What is the **primary** reason for your visit? _____

Check any of the following symptoms that pertain to the **primary reason** for today's visit:

- ☐ Allergy
- ☐ Allergy Testing
- ☐ Bad Breath
- ☐ Bleeding Ear
- ☐ Broken Nose
- ☐ Cough
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Earache
- ☐ Ear Bleeding
- ☐ Ear Drainage
- ☐ Ear Pressure
- ☐ Ear Ringing/Noise
- ☐ Ear Foreign Body
- ☐ Ear Wax
- ☐ Enlarged Tonsils
- ☐ Facial Injury
- ☐ Facial Swelling
- ☐ Hearing Aid
- ☐ Hearing Loss
- ☐ Heartburn
- ☐ Hoarseness
- ☐ GERD
- ☐ Imbalance
- ☐ Itchy eyes
- ☐ Laceration
- ☐ Lip Lesion
- ☐ Medication Refill
- ☐ Mouth Lesion
- ☐ Nasal Congestion
- ☐ Neck Mass
- ☐ Nosebleed
- ☐ Postnasal Drip
- ☐ Rash
- ☐ Runny Nose
- ☐ Sinus Infection
- ☐ Sinus Headache/Pressure
- ☐ Skin Cancer
- ☐ Skin Lesion
- ☐ Sneezing
- ☐ Snoring
- ☐ Swallowing Problems
- ☐ Swollen Glands
- ☐ Test Results
- ☐ Throat Pain/soreness
- ☐ Watery Eyes
- ☐ Wheezing

Other/comments: _____

_____

Have your symptoms changed since they began? ☐ Increased ☐ Decreased ☐ Unchanged

How quickly did your symptoms begin? ☐ Gradually ☐ Suddenly

Would you consider your symptoms? ☐ Constant ☐ Occasional ☐ Rare

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

PATIENT NOTICE & CONSENT

By signing below, I hereby acknowledge, agree and authorize all of the following:

a.) Accurate Information. I certify that the information provided on this form is accurate, complete and up to date to the best of my knowledge.

b.) Patient Rights and Responsibilities. I understand that the health care facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and how I may access my health records. I understand that I have the right to review this health care facility's Notice of Privacy Practices prior to signing this form.

c.) Consent for Treatment. I grant the health care facility, including its affiliated providers, physicians and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

d.) Routinely Performed ENT Procedures During an Office Visit. Our providers commonly use a special lighted instrument called a nasal endoscope. This scope or instrument allows for a thorough evaluation of the nose, sinuses and throat. Most insurance companies consider this an "in-office procedure" or "surgery," and it may show on your explanation of benefits or other insurance company correspondence as such. In addition, our providers may require a hearing test or audiogram, which will be done by one of our in-office audiologists. Each of these services is an additional charge that we will bill your insurance company. You acknowledge that you have been made aware of the possibility of additional financial responsibility.

e.) Release of Medical Information. I authorize the release of my health information to the health care facility in accordance with the health care facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my

referring physician, primary care physician and any physician(s) I may be referred to. The health care facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

f.) **Consent to Communication.** I consent to receive communications from the health care facility regarding appointment reminders, test results and other necessary health care-related information via phone, email or other channels.

g.) **Acknowledgment.** By signing below, I hereby acknowledge, agree and authorize all the above, and I authorize the health care facility to retrieve and review my medical history and authorize the health care facility to release the information required in obtaining procedure and medication authorization or the processing of any insurance claims.

h.) **Consent for Treatment of a Minor or Patient Under Guardianship.** By signing below, I am stating that I am the legal guardian of the patient, and I give consent/permission to J. Ben Hengy, D.O., Andrew E. Mendians, D.O., and other WMENT providers under their supervision to treat my child/ward.

HIPAA DISCLOSURE CONSENT

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Date: _____

I. **AUTHORIZATION**. Yes, I authorize Western Michigan to use or disclose the following: (check one)

- ☐ All my medical-related information. (Including SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, HIV, abortion or mental health treatment and diagnosis.)
- ☐ My medical information ONLY related to: _____
- ☐ My medical-related information from _____ to _____.
- ☐ _____

II. **DISCLOSURE.** The authorized party has my authorization to disclose medical records to: (Check one)

☐ Family (Please list names and relationships below):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Other/Physician(s) (List all others and the relationships):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SIGNATURE ACKNOWLEDGEMENT OF A PATIENT NOTICE & HIPAA DISCLOSURE

By signing below, I hereby acknowledge, agree and authorize to the above stated Patient Notice & HIPAA Disclosure.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

If a minor or ward:

Patient's Parent/Guardian Name: _____ ☐ Parent ☐ Guardian

Please Print

Patient's Parent/Guardian Signature: _____ Date: _____