

PEAK ENT ASSOCIATES

Patient Information – PLEASE PRINT AND FILL OUT COMPLETELY

Name _____
Last Name First Name M.I. Maiden

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
Area Code Area Code Area Code

Marital Status _____ Date of Birth ____ / ____ / ____ Age ____ SSN# _____ Gender M F

Patient Employment/Student Status Employed Student → Full-time OR Part-time Retired

Employer/School _____ Address _____

Physician who sent you _____ Is this your Primary Care Physician? Yes No
Last Name First Name

Above Physician's Phone _____ Preferred Pharmacy _____

PARENT OR RESPONSIBLE PARTY (if patient is a minor or under the guardian care of a third party)
Name _____
Last Name First Name M.I. Maiden
Address _____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Gender M F Date of Birth ____ / ____ / ____ SSN# _____ Relationship to patient _____
Employment/Student Status Employed Student → Full-time OR Part-time Retired
Employer/School _____ Address _____

INSURANCE INFORMATION

Primary Insurance:
Insurance Company _____
Ins. Address _____
Subscriber's Name _____
Subscriber's Date of Birth ____ / ____ / ____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

Secondary Insurance:
Insurance Company _____
Ins. Address _____
Subscriber's Name _____
Subscriber's Date of Birth ____ / ____ / ____
Subscriber's ID# _____
Group# _____
Patient's Relationship to Subscriber _____

EMERGENCY CONTACT – NOT LIVING WITH YOU

Name _____ Relationship _____ Phone _____
Address _____

Financial Policy & Acknowledgement of Receipt of Notice of Privacy Practices

I am responsible for payment of all rendered services; furthermore, I am responsible for all co-payments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at time of service.** I am responsible for providing correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I am responsible to pay all amounts owing as set forth herein. I agree that interest will accrue on all amounts 30 days and older at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amounts are referred to a third party collection agency, I agree that in addition to any other amounts allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11. **I understand that some medical procedures (hearing tests, CT scans, scopes, etc.) performed in the office are billed separately from the office visit.**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Peak ENT Associates's Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

Patient or Patient's Representative Signature Date

If signed by Representative, state name of Representative: _____
Relationship to Patient: _____

REVIEW OF SYSTEMS
PLEASE CHECK BOXES FOR ANY CURRENT OR RECENT PROBLEMS
(Problems which you have had within the past 3 months)

GENERAL

- Fevers
- Weight loss
- Fatigue
- Chills
- Night sweats

EYES

- Blurry or double vision
- Wear glasses
- Glaucoma

HEART/ BLOOD VESSELS

- Chest pain
- High cholesterol
- Palpitations
- Pain in legs with walking
- Swelling of feet / hands

LUNGS

- Frequent coughing
- Spitting up blood
- Shortness of breath
- Wheezing

GASTROINTESTINAL

- Loss of appetite
- Acid Reflux
- Ulcers
- Nausea or vomiting
- Frequent diarrhea
- Blood in stool
- Stomach pain

GENITOURINARY

- Frequent or painful urination
- Blood in urine
- Incontinence, or loss of bladder control
- Kidney stones

MUSCULOSKELETAL

- Joint pain
- Muscle weakness
- Muscle cramps
- Back pain
- Cold extremities

SKIN

- Sensitive skin or rash
- Change in hair or nails
- Change in skin color

NEUROLOGICAL

- Frequent headaches
- Seizures
- Numbness or tingling
- Tremors
- Head injury
- Confusion or memory loss

PSYCHIATRIC

- Anxiety
- Depression
- Bipolar disorder
- Trouble sleeping

ENDOCRINE

- Thyroid problems
- Heat or cold intolerance
- Excessive thirst
- Frequent urination

BLOOD AND LYMPH

- Bruising or Bleeding problems
- Clotting problems
- Anemia
- Blood transfusions
- Swollen glands or nodes

ALLERGY / IMMUNE

- Hayfever
- Weak immune system

None of the above apply.

I have reviewed the above and checked all symptoms which apply.

Initials

Date