

**PEAK ENT ASSOCIATES – PATIENT INFORMATION FORM**

Please Print Clearly and Fill Out Completely

Patient Name \_\_\_\_\_  
Last Name First Name M.I. Maiden  
Address \_\_\_\_\_  
Street City State Zip  
Home Phone ( ) \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_  
Cell Phone ( ) \_\_\_\_\_  
Employer \_\_\_\_\_  
Physician who sent you \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_

Gender -  Male  Female  
Marital Status \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SSN# \_\_\_\_\_  
\*In accordance with federal guidelines, please indicate the following:  
Preferred Language (if not English) \_\_\_\_\_  
Ethnicity -  Hispanic or Latino  Not Hispanic or Latino  
Race -  American Indian or Alaska Native  Asian  
 Black or African American  White  
 Native Hawaiian or Pacific Islander  Other Race

**PARENT or RESPONSIBLE PARTY** (if patient is under the age of 18 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 ( ) \_\_\_\_\_  
Patient's Relationship to the Responsible Party \_\_\_\_\_

Gender -  Male  Female  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SSN# \_\_\_\_\_  
Employer \_\_\_\_\_  
Employment Status -  Full-time or  Part-time

**INSURANCE INFORMATION** (Despite our scanning your insurance card, please fill in all fields)

**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 \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION** – By signing below, I authorize the doctors and staff at Peak ENT to disclose my protected health information, including but not limited to office notes, diagnostic tests, and lab results, to the below-named persons (e.g., a spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Individual #2 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** – I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, 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 so this office can bill my insurance as a courtesy to me. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, 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 in addition to any other amounts, such as interest or court costs. **I understand that some medical services performed in the office (audiology tests, CT scans, diagnostic scopes, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the 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 \_\_\_\_\_

# PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date symptoms started: \_\_\_\_\_ Primary reason for visit: \_\_\_\_\_

*What symptoms are you having? (check all that apply)*

**Nose / Sinuses:**

- Facial pain
- Facial pressure
- Congestion
- Nasal discharge
- Postnasal drip
- Loss of smell
- Bleeding
- Headaches
- Fever
- Bad breath
- Tooth pain
- Fatigue

**Allergy:**

- Congestion
- Itchy eyes, nose, or throat
- Runny nose
- Sneezing

**Neck / Thyroid:**

- Swelling or lump
- Thyroid nodules
- Hypothyroidism
- Hyperthyroidism
- Parathyroid disorder

**Other:**

- Facial weakness/paralysis
- Cosmetic concerns
- Skin growths / skin cancer

Other: \_\_\_\_\_

**LIST CURRENT MEDICATIONS:**

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**Ears / Balance:**

- Hearing loss
- Pain
- Drainage
- Dizziness
- Ear infections
- Ringing
- Pressure or fullness

**Throat / Mouth:**

- Sores
- Pain
- Loose teeth
- Jaw pain
- Bad breath
- Trouble swallowing
- Voice changes
- Throat tightness
- Cough / throat clearing

**Tonsils / Adenoids:**

- Recurrent infections
- Persistent infection
- Recurrent white debris
- Snoring
- Mouth breathing
- Toss and turn / poor sleep

**LIST ALLERGIES TO MEDICATIONS:**

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**MEDICAL HISTORY**

*(Check all that apply and list ALL your medical problems)*

- Asthma or lung problem
- Diabetes
- High blood pressure
- Sleep apnea
- Cancer (list type below)
- Heart problems
- Stroke

Other: \_\_\_\_\_

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**LIST ALL HOSPITALIZATIONS AND SURGERIES:**

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**SOCIAL HISTORY (check all that apply)**

- Alcohol use: \_\_\_\_\_ drinks per week
- At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)
- History of drug use
- Smoking Status:  Current every day smoker \_\_\_\_ packs per day
- Current some day smoker
- Former smoker
- Never smoker
- Tobacco use (other): \_\_\_\_\_

**FAMILY HISTORY (check if blood relatives have the following)**

DISEASE	RELATIONSHIP TO YOU
<input type="checkbox"/> Anesthesia problems	_____
<input type="checkbox"/> Bleeding tendency	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Thyroid/Parathyroid disorders	_____

**PEDIATRIC PATIENTS ONLY (check all that apply)**

- Premature birth (< 38 weeks) or very low birth weight
- Infection or other problem during pregnancy or birth
- Immunizations are up-to-date
- Developmental delay (speech, walking, other)
- Lives with someone who smokes
- Attends day care

## REVIEW OF SYSTEMS

PLEASE CIRCLE 'YES' FOR ANY CURRENT OR RECENT PROBLEMS

(Problems you have had within the past 3 months)

### ALLERGY/IMMUNE

Yes No Hay fever  
Yes No Weak immune system

### BLOOD and LYMPH

Yes No Anemia  
Yes No Blood transfusions  
Yes No Easy bruising or bleeding  
Yes No Swollen glands or nodes

### CARDIAC

Yes No Chest pain  
Yes No High blood pressure  
Yes No Other heart problems  
Yes No Palpitations  
Yes No Swelling feet/hands

### EARS

Yes No Ear aches  
Yes No Ear infections  
Yes No Hearing problems  
Yes No Tinnitus  
Yes No Vertigo

### ENDOCRINE

Yes No Diabetes  
Yes No Excessive thirst  
Yes No Frequent urination  
Yes No Heat or cold intolerance  
Yes No Thyroid problems

### EYES

Yes No Blurred vision  
Yes No Double vision  
Yes No Glasses or contacts  
Yes No Glaucoma

### GENERAL

Yes No Chills  
Yes No Fatigue  
Yes No Fevers  
Yes No Night sweats  
Yes No Recent weight change

### GASTROINTESTINAL

Yes No Blood in stool  
Yes No Frequent diarrhea  
Yes No Heartburn  
Yes No Loss of appetite  
Yes No Nausea or vomiting  
Yes No Stomach pain  
Yes No Ulcers

### GENITOURINARY

Yes No Blood in urine  
Yes No Frequent urination  
Yes No Kidney stones  
Yes No Loss of bladder control  
Yes No Painful urination

### LUNGS

Yes No Asthma  
Yes No Frequent coughing  
Yes No Shortness of breath  
Yes No Spitting up blood  
Yes No Wheezing

### MOUTH and THROAT

Yes No Dry mouth  
Yes No Frequent sore throats  
Yes No Sore tongue

### MUSCULOSKELETAL

Yes No Arthritis  
Yes No Back pain  
Yes No Joint pain  
Yes No Muscle cramps  
Yes No Muscle weakness

### NECK

Yes No Pain  
Yes No Stiffness in neck  
Yes No Swollen glands or nodes

### NEUROLOGIC

Yes No Frequent headaches  
Yes No Head injury  
Yes No Numbness or tingling  
Yes No Seizures  
Yes No Tremors

### NOSE and SINUSES

Yes No Frequent colds  
Yes No Nasal stuffiness  
Yes No Sinus troubles

### PSYCHIATRIC

Yes No Anxiety  
Yes No Depression

### SKIN

Yes No Changes in hair or nails  
Yes No Color change  
Yes No Dryness  
Yes No Rashes

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

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_