



PATIENT HISTORY SHEET

PATIENT NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

NAME AND LOCATION OF THE PHARMACY THAT YOU USE: _____

PRIMARY CARE PHYSICIAN OR REFERRING DOCTOR: _____

CURRENT MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS):

ALLERGIES TO MEDICATIONS: YES NONE (UNKNOWN)

ENVIRONMENTAL (INCLUDING LATEX OR CONTACT ALLERGIES): YES NONE (UNKNOWN)

FOOD ALLERGIES: YES NONE (UNKNOWN)

PLEASE INDICATE ALL PREVIOUS ILLNESSES AND HEALTH PROBLEMS FOR BOTH YOURSELF AND YOUR FAMILY.
(CHECK APPROPRIATE BOX)

	YOURSELF		FAMILY		RELATION		YOURSELF		FAMILY		RELATION
	YES	NO	YES	NO			YES	NO	YES	NO	
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA OR LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	PROSTATE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHEST PAIN WITH EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	POLIO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NERVE OR PSYCHIATRIC DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RINGING IN THE EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	UNUSUAL CHILDHOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEARING LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ULCER OR STOMACH DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	NECK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FEVERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
YELLOW JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV VIRUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

OTHER PHYSICAL RESTRICTIONS: _____

ALL PREVIOUS SURGERIES, INCLUDING THE YEAR: _____

IMMUNIZATIONS: UP TO DATE? YES NO PATIENTS OVER 65 YEARS OLD: IMMUNIZATIONS FOR: FLU SHIINGLES PNEUMONIA

DO YOU USE TOBACCO? DO YOU USE ALCOHOL? DO YOU USE ASPIRIN? RECREATIONAL DRUGS?

YES NO NEVER YES NO NEVER YES NO NEVER YES NO NEVER

IN THE PAST OR PRESENT? IN THE PAST OR PRESENT? IN THE PAST OR PRESENT? IN THE PAST OR PRESENT?



Ear, Nose and Throat Associates of Northern Colorado Financial and Contact Policy

Welcome to Ear, Nose and Throat Associates of Northern Colorado, P.C. Please take a few minutes to review the following information.

PATIENT RESPONSIBILITIES:

Co-payments: We do not bill for copayments. Co-payments are due at the time of service.

Referrals: If your insurance requires a referral and you do not provide one at the time of service, you are responsible for any charges incurred.

Cancellations: A \$25.00 cancellation fee will be assessed if the appointment is not cancelled 24 hours in advance.

Return Checks: A \$20.00 fee will be assessed on returned checks.

If you have health insurance with which we participate:

- We will bill your insurance claim for you and we expect any required copayment at the time of service

If we do not participate with your insurance:

- We will do a courtesy billing for you and we expect payment of deductibles and/or coinsurance to be paid in full at the time of service

MEDICAID PATIENTS:

- If services provided are not a covered benefit you will be responsible for any charges incurred.

If you do not have insurance, we expect payment at the time of service. We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER and CARE CREDIT (3-month plan).

Surgical deductibles will be collected prior to surgery. Balances are due after a statement has been issued. If payment arrangements need to be made, payment in full must be within 90 days. A one-time \$25.00 rebilling fee will be assessed to accounts after 90 days. Accounts over 90 days are subject to collection. If your account is placed in full collection or if we write off a bad debt you will be dismissed from this practice. Refunds will be returned in the same form tendered.

I have read and agree to the above.

Date: _____

Signature: _____

Print Name: _____

You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or e-mails, using an e-mail address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I/We have read this disclosure and agree that we may be contacted as described above.

Date: _____

Signature: _____

Release of (Medical) Records

I authorize this clinic to furnish medical information regarding the treatment of my current injury/illness to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related injuries).

Date: _____

Signature: _____