6823 ISAACS ORCHARD RD OR 2900 MEDICAL CENTER PKWY
SPRINGDALE, AR 72762 BENTONVILLE, AR 72712

PHONE: 479-750-2080
FAX: 479-750-2082

Thank you for choosing the Ear, Nose and Throat Center of the Ozarks to provide your health care. Enclosed are the forms for you to review or complete prior to your appointment. **Please complete and bring with you to your appointment along with you Insurance Cards and complete list of medications.**

The staff at the Ear, Nose and Throat Center of the Ozarks is committed to providing thorough examinations, comprehensive diagnoses and treatments and detailed answers to your questions. Please assist your doctor by completing the questionnaire(s) enclosed in the packet. **Please fill out every item**. It is important for your doctor to know that you have reviewed every area of this form.

Thank you for your time and assistance. If you have any questions when completing the accompanying forms, please do not hesitate to ask for our assistance.

Patient Name:____

Appt. Date:____________ Arrival Time: _______________________

Seeing Dr._______________________________

Patient Information **Acct #**______________

Last Name______________________________First_____________________________Middle Initial________

Nickname_________________________________ Social Security #____________________________________

Sex M F (circle) Marital Status S M W D Date of Birth____________(mm/dd/yyyy) Age_____Weight_______Height_____

Address______________________________________ City____________________ State_____Zip___________

Primary Phone Number (   )______-____________ Work Phone (   )______-________________________

EMERGENCY Phone Number (   )______-______________ Email_____________________________________

Please circle your preferred method of contact: Phone Text Email

Race/Ethnicity___________________________ Language Preference_________________________________

Employer___________________________________ Occupation____

Name of Insurance Company___________________________ Group Number______________________________

Name of Primary Insured_______________________________ I.D. Number______________________________

Do you have secondary insurance? YES NO Name of Secondary Insurance Company_______________________

Spouse's Name____________________________________ S.S.#_________________ Date of Birth_____________

Spouse's Employer__________________________________ Work Phone Number (   )______-_____________

If the patient is a minor, please fill in the following information:

Mother's/Guardian's Name_________________________ S.S.#____________________ Date of Birth___________

Employer____ Work Phone Number(   )_______-_______________

Father's Name___________________________ S.S.#________________________ Date of Birth_____________

Employer____ Work Phone Number(   )_______-_______________

Name of Referring Physician or Self-Referred______________________________

Name of General/Family Doctor_____________________ Reason for Today's Visit_____________________________

Pharmacy Preference (please include location/city)____

I understand that the payment is expected when services are provided. Payment in full will be required if insurance cannot be verified.

Method of payment for today's visit: CASH CHECK CREDIT CARD

I authorize Ear, Nose and Throat Center of the Ozarks to provide medical care. I authorize the release of any medical information necessary to provide medical care and process insurance claims and payments of medical benefits to physician and supplier.

Signature____ Date____________________________________

Name____

Please complete all sections to the best of your knowledge. Any information you can provide will help us to serve you better.

Medical Allergies

Are there medications which you have had an allergic reaction or unpleasant side-effect? YES NO
If yes, please list the medication and describe reaction in the space below. If more than space allows, please present a list.

Medication	Reaction	Medication	Reaction

Are you allergic to any of the following? If yes, please circle. LATEX TAPE IODINE or CONTRAST DYE

Do you have any other allergies? If so, please list them____

Personal Medical History: Please specify any medical problem or diagnosis you have with the following.

Ears ______________________________________

Nose or sinuses________________________________

Tonsils or Adenoids___________________________

Throat or Voice______________________________

Esophagus (food or swallowing pipe) _______________________

Heart______________________________________

Thyroid, parathyroid, or endocrine system ___________________

Lungs______________________________________

Immune system, HIV, Lymph nodes________________________

Gall Bladder or pancreas__________________________

Neurologic disease, epilepsy, or seizures_____________________

Kidneys or Bladder_______________________________

Hypertension/High Blood Pressure_________________________

Back, neck, or spine_______________________________

Excessive bleeding or bleeding tendency_____________________

Bones, muscles, or joints (including TMJ) ____________

Bowel (Small or large intestine, rectum) _____________________

Stomach or stomach ulcers_________________________

Liver disease, hepatitis, jaundice, spleen_____________________

Any eye problem not corrected by glasses_____________

FEMALES: Uterus, ovaries, breasts__________________________

MALES: Prostate, penis, testicles____________________

Have you had or do you have any medical conditions that you have not listed? YES NO

If yes, please list them____

Have you ever been treated with radiation (circle one)? NEVER IN THE PAST CURRENTLY

If yes, when?_________________________

If yes, how long?_________________________

Do you have any personal history of head or neck cancer? YES NO

If yes, please list what type and how treated____

Have you ever been hospitalized? YES NO

If yes, please list reasons and dates____

NAME: ____

Please list any surgery you have had and date of surgery if known.

Please list ALL medications you take and the reason you take them. IF YOU HAVE A LIST OF MEDICATIONS, please hand it to a staff member when you turn in your paper work.

Medication	Reason for Taking	Medication	Reason for Taking

Family Medical History

Do you have any family history of bleeding disorders or complications with anesthesia? YES NO

If yes, please list them____

Do you have any family history of head or neck cancer? YES NO

If yes, please list them____

Is there a history of other medical conditions in your family? YES NO

If yes, please list them____

Social History

Do you have an occupation, hobbies or other activities that have exposed you to loud noise? YES NO

Do you have regular hearing screening at your job? YES NO When was your last hearing screening?____________

Have you ever used tobacco (including smoking or smokeless tobacco)? NEVER PAST USE CURRENT USE

If yes, what type and how much?____________________ **If yes, how long?**________________

Have you ever used alcohol (circle one)? NEVER PAST USE CURRENT USE

If yes, how much?________________ **If yes, how long?**________________

Are you or have you been exposed to second hand smoke? NEVER IN THE PAST CURRENT USE

If yes, at home or at work? _______ **If yes, how much?**______________ **If yes, how long?**______________

NAME: ____

Have you ever had any of the following treatments or problems in the ear, nose, throat, head or neck regions (please circle):

Hearing Aids Yes No When__________
Treatment for Vertigo Yes No What/When__________
Ear Drops Yes No What/When__________
Ear Trauma Yes No What/When__________
Ear Cleaning Yes No What/When__________

Sinus/Allergy Medication Yes No What/When__________
Nasal Sprays Yes No What/When__________
Allergy Shots Yes No What/When__________
Nasal Irrigations/Washes Yes No What/When__________
Nasal Trauma Yes No What/When__________

Systems Review:

In the past few months, have you had:

- ☐ fever within the last month
- ☐ night sweats
- ☐ excessive bruising
- ☐ enlarged lymph nodes or glands
- ☐ change in skin or in a mole
- ☐ weight loss of more than 10lbs
- ☐ double or blurred vision
- ☐ seizures
- ☐ headache
- ☐ tick or insect bite(s)
- ☐ animal bite or scratch
- ☐ recurrent infections

- ☐ diminished hearing
- ☐ dizziness or vertigo
- ☐ ringing in the ears
- ☐ ear fullness
- ☐ drainage from the ears
- ☐ ear injury

- ☐ sinus problems
- ☐ significant headaches
- ☐ seasonal allergies
- ☐ post nasal drainage
- ☐ sneezing/itchy nose
- ☐ loss of sense of smell
- ☐ runny nose
- ☐ nose bleeds
- ☐ face pain or pressure
- ☐ sinus infection requiring antibiotics
- ☐ difficulty breathing through your nose
- ☐ NONE

Are you bothered by:

- ☐ wheezing
- ☐ coughing
- ☐ swallowing difficulty
- ☐ hoarseness
- ☐ speech difficulty or changes
- ☐ chronic halitosis/"bad breath"
- ☐ snoring
- ☐ throat pain
- ☐ pain when you drink citrus
- ☐ NONE

Have you:

- ☐ had "heartburn" or reflux
- ☐ coughed up sputum
- ☐ been exposed to TB
- ☐ been diagnosed with asthma
- ☐ coughed up blood
- ☐ shortness of breath

- ☐ "blacked out" (lost consciousness)
- ☐ had weakness or tingling
- ☐ had neurological changes

- ☐ had abnormal pain or swelling of the legs or feet
- ☐ had irregular heart beats
- ☐ had heart valve problems
- ☐ had chest pain or pressure
- ☐ had rapid heart beats
- ☐ NONE

Do you have:

- ☐ stomach trouble
- ☐ significant constipation
- ☐ significant diarrhea
- ☐ blood in your bowel movements
- ☐ nausea or vomiting
- ☐ pain in your abdomen

- ☐ depression
- ☐ anxiety
- ☐ fatigue
- ☐ decreased appetite
- ☐ heat or cold intolerance (that is different from others around you)

- ☐ excessive urination
- ☐ burning with urination
- ☐ pain with urination
- ☐ difficulty completely emptying your bladder
- ☐ difficulty with leaking urine from your bladder

- ☐ joint pain, stiffness, or swelling
- ☐ muscle pain or stiffness
- ☐ back pain or stiffness
- ☐ NONE

Signature ____ **Date**______________________

Thank you very much for your time. These forms will help us serve you better.