New Patient Information

First Name: ______________________ MI. ________Last Name + Suffix: _________________

Prev Last Name: __________________ Date of Birth: _________ Sex: M or F

Race: __________ Language: ____________ Ethnicity: __________SSN: ______________

Address: ____

City/State: _______________________________ Zip Code: _____________________

Home Phone: ______________________________ Work Phone: ___________________

Mobile Phone: _____________________________ Email: ________________________

Contact Preference: □ Home □ Mobile □ Work Marital Status: __________________

Referring Physician: _________________________ PCP: ___________________________

If Patient is a minor:

Mother's First Name: _________________________ Mother's Last Name: _____________

Father's First Name: __________________________ Father's Last Name: ______________

Pharmacy Information:

Pharmacy Name: _____________________________ Pharmacy Number: _______________

Pharmacy Address: ____

Medication History Authority □ Yes □ No
(Gives us authorization to get your medication history from your pharmacy)

Insurance Information

Name of Subscriber to Insurance: _______________________ Relationship: _____________

Subscriber's DOB: ______________

If **TRICARE:** □ Standard □ Prime □ For Life Sponsor's SSN: _________________

Reason for Visit ____

Medications

List Current Medications (please include dosage):

____

____

List Drug Allergies (please include reaction):

____

____

Medical Conditions

□ Allergies	□ Cancer	□ Glaucoma	□ Kidney Disorder
□ Anemia	□ Depression	□ Hearing Loss	□ Migraines
□ Anxiety Disorder	□ Developmental Delay	□ Heart Attack	□ Sleep Disorders
		□ Heart Conditions	□ Speech Delay
□ Arthritis	□ Diabetes	□ High Cholesterol	□ Stroke
□ Asthma	□ Emphysema	□ Hypertension	□ Thyroid Problem
□ Bleeding Disorder	□ Fibromyalgia	□ Autoimmune Disorder	

Past Surgeries (please include year of surgery):

□ Ear Surgery ___________________________

□ Neck Surgery (ie thyroid) ________________

□ Facial Surgery _________________________

□Tonsillectomy/ Adenoidectomy ________

□ Nasal / Sinus Surgery ____________________

□ Vocal Cord Surgery _________________

□ Other ____________________________________

Social & Family History

Do you smoke? Y N If yes, how often? _______ How long? ______

Do you drink alcohol? Y N If yes, how often? ____________

What is your Occupation? ____

Has anyone in your immediate family had?

PROBLEM	RELATIONSHIP	ONSET AGE	AGE OF DEATH	NOTES
Bleeding Problems				
Cancer				
Diabetes				
Heart Problems				
Kidney Disease				
Strokes				
Thyroid				
Tuberculosis				
Other				

Reviewing Physician's Initials: ___________________ Date: ______________________