LUFKIN ENT & ALLERGY

PATRICIA MCADAMS, M.D.
BRIAN HUMPHREYS, M.D., F.A.C.S.

PATIENT INFORMATION (Please Print Clearly)

Patient Name: _____ Sex (Circle One): Male Female

Preferred Name/Alias of Patient: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Marital Status (Circle One): Single - Married - Divorced - Widowed - Decline

Name of Parent(s) of Minor: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Place of employment: _____

Guarantor/Family Email: _____

Preferred pharmacy: _____

Preferred hospital: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

REFERRAL INFORMATION

Referring Physician: _____ Address: _____

Primary Care Physician: _____ Address: _____

GOVERNMENT MANDATED INFORMATION

Preferred language (Circle One): English - Spanish - Decline If, Other. Please specify: _____

Race (Circle One): White - Am. Indian - Black/African American - European - Japanese - Korean - Decline

Ethnicity (Circle One): Not Hispanic/Latino - Mexican/Hispanic/Latino - Cuban - Dominican - Puerto Rican - Decline

Contact Preference: Portal - Home Phone - Work Phone - Cell Phone - Mail

RESPONSIBLE PARTY

☐ Check if the same as patient information

Person responsible for payment: _____ Date of Birth: _____

Relationship to patient: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Employer: _____ Employer Phone: _____

Spouse name: _____ Spouse DOB: _____ Spouse SSN: _____

ENT - PATIENT HISTORY

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PATIENT NAME: _____

WHAT DOCTOR SENT YOU HERE? _____

WHICH MEDICINES ARE YOU ALLERGIC TO? _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT MEDICATIONS HAVE YOU TAKEN FOR THIS? _____

HAVE YOU BEEN SEEN OR TREATED BY ANY DOCTOR IN PAST 12 MONTHS FOR THIS? _____ IF SO, WHO? _____

HOW MANY TIMES IN THE LAST 12 MONTHS HAS THIS OCCURRED? _____

ALL MEDICATIONS PRESENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

PLEASE CIRCLE ANY CONDITIONS THAT THE PATIENT HAS NOW OR IN THE PAST.

ACID REFLUX:	Y	N		HEPATITIS	Y	N	WHAT KIND _____
AIDS/HIV POSITIVE ...	Y	N		HIGH CHOLESTEROL	Y	N	
ALZHEIMER'S DISEASE ...	Y	N		HOARSENESS	Y	N	
ANEMIA	Y	N		HYPERTENSION	Y	N	
ARTHRITIS:	Y	N	WHAT KIND	KIDNEY DISEASE	Y	N	
ASTHMA	Y	N		LIVER DISEASE	Y	N	
CANCER	Y	N	WHAT KIND	LUNG DISEASE	Y	N	WHAT KIND
DIABETES	Y	N	WHAT KIND	PARATHYROID DISEASE ..	Y	N	
FIBROMYALGIA	Y	N		SJÖGREN	Y	N	
GOUT	Y	N	WHAT KIND	STROKE	Y	N	
HEART PROBLEMS	Y	N	WHAT KIND	THYROID DISEASE	Y	N	WHAT KIND
				TUBERCULOSIS	Y	N	

SOCIAL HISTORY DO YOU CURRENTLY USE?

ALCOHOL:	Y N	CURRENT DRINKER..	Y N	HOW MUCH PER DAY? _____	WHEN DID YOU STOP? _____	HOW LONG DID YOU DRINK? _____
CIGARETTES:	Y N	CURRENT SMOKER..	Y N	HOW MUCH PER DAY? _____	WHEN DID YOU STOP? _____	HOW LONG DID YOU SMOKE? _____
CHEWING TOBACCO:	Y N	CURRENT USER....	Y N	HOW MUCH PER DAY? _____	WHEN DID YOU STOP? _____	HOW LONG DID YOU DIP? _____
CIGARS:	Y N	CURRENT SMOKER..	Y N	HOW MUCH PER DAY? _____	WHEN DID YOU STOP? _____	HOW LONG DID YOU SMOKE? _____
SNUFF:	Y N	CURRENT USER....	Y N	HOW MUCH PER DAY? _____	WHEN DID YOU STOP? _____	HOW LONG DID YOU USE? _____

LIST ALL SURGERIES: _____

_____

_____

_____

_____

_____

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REVIEW OF SYSTEMS

DO YOU NOW HAVE ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS? CIRCLE YES OR NO. PLEASE EXPLAIN ANY YES ANSWERS IN SPACE PROVIDED.

CONSTITUTIONAL/GENERAL

CHILLS	Y	N
FATIGUE	Y	N
FEVER	Y	N
LOSS OF APPETITE	Y	N
HEADACHES	Y	N
WEIGHT GAIN	Y	N
WEIGHT LOSS	Y	N

EAR/NOSE/THROAT

EAR DRAINAGE	Y	N
EAR BLEEDING	Y	N
EAR FULLNESS	Y	N
EAR INFECTION	Y	N
EAR ITCHING	Y	N
EAR PAIN	Y	N
EAR PULLING	Y	N
RINGING IN THE EARS	Y	N
VERTIGO	Y	N
HEARING LOSS	Y	N
NASAL CONGESTION	Y	N
NOSE BLEEDS	Y	N
SINUS DRAINAGE	Y	N
SINUS PRESSURE	Y	N
SNORING	Y	N
SORE THROAT	Y	N

CARDIOVASCULAR

FAINTING	Y	N
HEART TROUBLE	Y	N
HIGH BLOOD PRESSURE	Y	N
PALPITATIONS	Y	N
CHEST PAIN	Y	N

RESPIRATORY

BRONCHITIS	Y	N
COUGH	Y	N
SHORTNESS OF BREATH	Y	N
WHEEZING	Y	N

ENDOCRINE

EXCESSIVE THIRST	Y	N
HOT FLASHES	Y	N
NIGHT SWEATS	Y	N
TIRED/SLUGGISH	Y	N
HAIR LOSS	Y	N
BRITTLE NAILS	Y	N

GASTROINTESTINAL

ABDOMINAL PAIN	Y	N
DIARRHEA	Y	N
IRRITABLE BOWEL SYNDROME	Y	N
NAUSEA/VOMITING	Y	N
ULCERS	Y	N
INDIGESTION/HEARTBURN	Y	N

INFECTIOUS DISEASE

HIV	Y	N
MRSA, STAPH INFECTION	Y	N
SERRATIA MARCESCENS	Y	N
HEP C	Y	N
CORONA VIRUS	Y	N

MUSCULOSKELETAL

BACK PAIN	Y	N
JOINT PAIN	Y	N
KNEE PAIN	Y	N
MUSCLE PAIN	Y	N
NECK PAIN	Y	N

NEUROLOGICAL

HEADACHES / MIGRAINE	Y	N
LOSS OF CONSCIOUSNESS	Y	N
TREMORS	Y	N
NUMBNESS/TINGLING	Y	N
STROKE	Y	N

HEMATOLOGIC

BLEEDING DISORDER	Y	N
SWOLLEN GLANDS	Y	N

SKIN/INTEGUMENTARY

SKIN LESIONS	Y	N
ITCHY SKIN	Y	N
DRY SKIN	Y	N
PROBLEM SCARRING	Y	N
SKIN RASH	Y	N
SKIN CANCER	Y	N
SUSPICIOUS LESION	Y	N

GENITOURINARY

BURNING OR PAIN WITH URINATION	Y	N
URINE RETENTION	Y	N
URINATION FREQUENCY	Y	N

PSYCHIATRIC

FEELING SEVERELY DEPRESSED	Y	N
HAVING EVER CONSIDERED SUICIDE	Y	N

EYES

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
EYE PAIN	Y	N
ITCHY EYES	Y	N

ALLERGIES/IMMUNOLOGIC

SEASONAL ALLERGIES	Y	N
DRUG ALLERGIES	Y	N
IMMUNITY DISORDER	Y	N
ARE IMMUNIZATIONS CURRENT	Y	N

REACTION TO ANESTHESIA	Y	N
ALLERGIC TO LATEX	Y	N

FAMILY HISTORY

HEARING LOSS ..... Y N
WHO _____

EAR SURGERY ..... Y N
WHO _____

TINNITUS ..... Y N
WHO _____

VERTIGO ..... Y N
WHO _____

HEART CONDITION ..... Y N
WHO _____

CANCER ..... Y N
WHO _____

BROTHERS _____

SISTERS _____

SONS _____

DAUGHTERS _____

PETS _____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPPA Privacy Policy for Lufkin ENT & Allergy.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize Lufkin ENT & Allergy to release medical information required to process my claim.
- I have read and understand the Financial Policy for Lufkin ENT & Allergy:
  Our office will accept cash, personal checks, Visa, MasterCard, Discover, American Express & Care Credit cards. A statement of fees will be sent regularly. Regardless of medical insurance coverage, our clinic relies on you for settling your account. You are ultimately responsible for all clinic and surgery fees relating to your care. Your health insurance policy is an agreement between you and your health insurance carrier. Please be aware that some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance left unpaid by your insurance company. If you need to make special arrangements for payment, please contact our office manager.
- I understand that Lufkin ENT & Allergy does not accept certain heath insurances such as HMO insurance plans and any expenses incurred are my responsibility.
- I understand that Lufkin ENT & Allergy has a No Show policy and a fee of $25.00 will be charged if appointment is not cancelled within 24 hours prior to my appointment. This is not covered by insurance.
  I understand if I miss three consecutive appointments I will be dismissed as a patient.
- I understand that Lufkin ENT & Allergy will charge a fee of $30.00 if a check is returned to their office from my bank.
- I understand that if surgery is recommended, my insurance benefits will be verified. A cost estimate which shows my financial responsibility will be explained. This may require a deposit for the surgery which is determined by my insurance deductible and co-insurance.
- I authorize Lufkin ENT & Allergy to obtain/have access to my medication history.
- I authorize Lufkin ENT & Allergy to contact me by mobile phone.
- I authorize Lufkin ENT & Allergy to contact me with information regarding hearing products.
- I understand that Lufkin ENT & Allergy includes Brian F Humphreys MD, FACS, PA, and Patricia McAdams, MD.

- I authorize the following individuals to access my medical information, including all billing and/or insurance transactions:

Name: _____ Relationship _____ Phone #: _____

Name: _____ Relationship _____ Phone #: _____

Name: _____ Relationship _____ Phone #: _____

Patient/Guarantor signature: _____ Date: _____