West Valley Ear, Nose and Throat, P.C.

Phoenix: 16841 N 31st Avenue, Bldg2, Ste.117, Phoenix, AZ 85053
Phone 602.843.4844* Fax 602.843.4846
Surprise: 14877 W. Bell Rd., Suite 101, Surprise, AZ 85374
Phone 623.234.4640 * Fax 623.234.4642

1) Complete each line entirely or indicate N/A. 2) Print clearly and sign authorization.

PERSONAL INFORMATION

Name:_____ **Date of Birth:** _____
Last First MI

Sex:_____ **Martial Status:**_____ **Social Security No.:**_____

Email Address:_____ **Home Phone:**_____**Cell Phone:**_____

Home Address
Street:_____
City:_____ **State:**_____ **Zip:**_____

Employed Retired Part Time Student Full Time Student (Circle One)

Employer:_____ **School:** _____ **Occupation:**_____
** **Primary Care Physician/Pediatrician:** _____
** **Pharmacy Information:**_____
Name Phone #/ Cross Street

Parents (Responsible Parties)

Mother:_____
DOB:_____**SS#:** _____
Home/Cell #:_____**Work#:** _____
Address:_____
City: _____**State:**_____**Zip:** _____
Employer:_____

Father:_____
DOB:_____**SS#:**_____
Home/Cell #:_____**Work#:** _____
Address _____
City: _____**State:**_____**Zip:** _____
Employer:_____

Insurance Information

Specialist Co-Pay $_____

Primary

Name:_____
ID Number: _____
Group Number: _____
Address:_____
Phone #: _____
Cardholder's Name: _____
DOB: _____ SSN:_____

Secondary

Name:_____
ID Number: _____
Group Number: _____
Address:_____
Phone #: _____
Cardholder's Name: _____
DOB: _____ SSN:_____

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Patient Communication and Authorization

Emergency Contact Name_____
Relationship: _____**Contact Number:** _____

THE FOLLOWING PERTAINS TO THE ABOVE NAMES PATIENT (CIRCLE ALL THAT APPLY)

Okay to call Home and Leave Messages Don't Call Home Phone Okay to Call Work Number
Call Work Number Only Don't Call Work Number

OTHER THAN YOURSELF, TO WHOM MAY WE RELEASE YOUR PROTECTED HEALTH OR BILLING INFORMATION?

I certify that all the information listed above is, to the best of my knowledge, true and correct.

Patient Signature: _____**Date:**_____

(or guardian if patient is a minor, under the age of 18 years old.)

West Valley Ear, Nose and Throat, P.C.

INTIAL MEDICAL HISTORY

(Confidential)

Date:_____

To Our Patients:

Thank you for completing the following history form. It will help us greatly in the overall evaluation of your problem. We will develop your history further in a few minutes in the examining room. Until then and thereafter, if you have any questions for our staff, please don't hesitate to ask.

Male ☐

Name:_____**Age:**_____**DOB:**_____**Female**☐

Last First MI

Referred to this office by:_____ **Currently under the care of a physician?** Yes☐No☐

If yes, whom? _____ **For what diagnosis?**_____

For what problem did you come to see the doctor today?

_____

_____

_____

Have you been treated for an ear, nose or throat problem before? Yes☐No☐

M.D.'s Name:_____ **If yes, describe the previous problem:**_____

_____

List any medications currently taken or applied whether prescribed, over the counter or home remedy types:_____

_____

_____

Are you allergic to any medications? Yes☐No☐ **If yes, please list:**_____

_____

Are you currently using tobacco? Yes☐No☐ **If yes, how much?**_____**How long?**_____

If no, have you ever used tobacco? Yes☐No☐ **If yes, how much?**_____**How long?** _____

When did you quit? _____

History of drug abuse? Yes☐No☐ **History of alcohol use?** Yes☐No☐ **If yes, how much?**_____

Previous surgeries:_____

_____

Any past history of: (If YES, please check and elaborate briefly below.) If, NONE please check here ☐

☐Asthma	☐Diabetes	☐ Heart Trouble	☐High Blood Pressure	☐ Nervous Disorder ☐HIV
☐ Hay Fever	☐ Ulcers	☐Liver Trouble/ Hepatitis	☐ Kidney Disease	☐Bleeding Disorder ☐Other
☐ Eczema	☐ Alcoholism	☐Tuberculosis	☐Eye Disease	☐ Bruising Easily

Explain:_____

_____

I certify that all the information listed above is, to the best of my knowledge, true and correct.

Patient Signature: _____**Date:**_____

(or guardian if patient is a minor, under the age of 18 years old.)

Nurse's Signature: _____**Date:**_____

Reviewed and confirmed by: _____**Date:**_____

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Medical History Questionnaire 2

Past Medical History			**Surgical History**		
Hypertension		Yes☐No☐	No ENT surgery		Yes☐No☐
Diabetes		Yes☐No☐	Tonsillectomy		Yes☐No☐
Asthma		Yes☐No☐	Adenoidectomy		Yes☐No☐
Hay Fever		Yes☐No☐	Ear Tubes		Yes☐No☐
Heart Disease		Yes☐No☐	Nose Surgery		Yes☐No☐
Heart Murmur		Yes☐No☐	Eye Surgery		Yes☐No☐
Kidney Disease		Yes☐No☐	Thyroid Surgery		Yes☐No☐
Bleeding Disorder		Yes☐No☐	Brain Surgery		Yes☐No☐
Ulcers		Yes☐No☐	Gall Bladder		Yes☐No☐
Nervous disorder		Yes☐No☐	Heart Surgery		Yes☐No☐
Bruising Easily		Yes☐No☐	Hernia Repair		Yes☐No☐
Liver Trouble		Yes☐No☐	Appendectomy		Yes☐No☐
Hepatitis		Yes☐No☐	Spine/Joint		Yes☐No☐
Liver Disease		Yes☐No☐	Colo-Rectal		Yes☐No☐
HIV		Yes☐No☐	Spleen Surgery		Yes☐No☐
Sleep Apnea		Yes☐No☐	Colonoscopy		Yes☐No☐
Family History			Endoscopy		Yes☐No☐
Father's Medical History			Other		Yes☐No☐
	☐Diabetes	☐ Heart Disease	**Social History**		
	☐ Hypertension	☐ Cancer	Do you smoke?		Yes☐No☐
Mother's Medical History					
	☐Diabetes	☐ Heart Disease	Do you drink alcohol?		Yes☐No☐
	☐ Hypertension	☐ Cancer			
Sibling's Medical History			History of drug abuse?		Yes☐No☐
	☐Diabetes	☐ Heart Disease			
	☐ Hypertension	☐ Cancer	Are you employed?		Yes☐No☐

WEST VALLEY EAR, NOSE, AND THROAT, P.C.

ACKNOWLEDGEMENT FORM

- I, to the best of my knowledge gave the correct insurance information. I also understand that it is my responsibility to update any and all changes each visit. I have read the **insurance policy** in full and understand the policy.
- I have read and acknowledged West Valley ENT's **Appointment Policy.**
- I have read and understand West Valley ENT's **Billing** and **Financial Guidelines Policies**.
- I have read the **HIPPA** notice of **Privacy Practices Act**.

Patient Signature:_____ **Date:**_____
(or guardian if patient is a minor, under the age of 18 years old.)