PATIENT INTAKE FORM

Name: _____ Email: _____

Phone: _____ □ Cell □ Home DOB: _____

Address: _____

Referred By: _____

Primary Care Doctor: _____

CHIEF COMPLAINT (reason you are here today):

_____

_____

_____

MEDICATION LIST (Medication, Dose, and Frequency): If you do not have a medication list, including over-the-counter items, please complete this section.

_____

_____

_____

_____

Pharmacy and Location:_____

ALLERGIES TO MEDICATION: (name of medication and type of allergic reaction)

_____

_____

Emergency Contact Name: _____ **Phone:** _____

Relationship to Patient: _____

Other Service Interest

☐ Allergy testing/ treatment

☐ Sleep Apnea *(symptoms: snoring, tired during the day, stop breathing while sleeping, high BP)*

Consent to treat

I hereby consent to receive medical treatment from ENT Surgical Consultants and its healthcare providers. I understand that the healthcare providers may include physicians, physician assistants, nurses, and other staff members. I authorize the healthcare providers to perform examinations, tests, procedures, and treatments deemed necessary for my medical care. I understand that I have the right to ask questions about my treatment and to participate in decisions about my healthcare. I acknowledge that I have received a copy of the Notice of Privacy Practices and understand my rights regarding the use and disclosure of my health information. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on this consent.

Financial Responsibility

As you are seeing a specialist at ENT Surgical Consultants, various tests like nasal scopes, wax removal, hearing tests, biopsies, and CT scans may be required during your visit, with additional charges. Please be aware that insurance coverage for these services may vary, and it's your responsibility to understand your coverage, pay your balance, and co-pay.

Self-pay patients will be billed for any remaining balance after their visit, even if a down payment was made.

Acknowledgment:

_____	_____	_____
Patient Signature	Printed Name	Date

For Minors:

_____	_____	_____
Parent/Legal Guardian Signature	Printed Name	Date

_____

Patient Name

_____

Relationship to Patient