Date:_____

# Patient Demographics

**Name:**_____
(First) (Middle) (Last)

**DOB** (mm/dd/yy)_____ **Social Security #:**_____

**Address:**_____

**City**_____ **State:**_____ **Zip Code:**_____

**Mobile:** (___)_____ **Home:** (___)_____ **Work:** (___)_____

**Email address**: _____ **Marital Status:**_____

**Ethnicity** (**please circle**): Hispanic or NonHispanic **Sex:** M or F ☐ ☐

**Preferred Language:**_____

**Within the past year have you received either of the following vaccines?**

**(Please Circle)** Pneumonia or Influenza **Date:**_____

**Race** (please check one): _____American Indian _____Asian
_____Black or African American _____Caucasian
_____Native Hawaiian or Other Pacific Islander

**Smoker:** _____Never smoker _____Unknown if ever smoked
_____Former smoker _____Smoker, current status unknown
_____Current every day smoker _____Current some day smoker
_____Heavy tobacco smoker _____Light tobacco smoker

**Preferred Pharmacy**_____ **Location:**_____

**Previous MRI or CT of the head or neck:**
Where:_____
When:_____
Results:_____

**Height:**_____ **Weight:**_____

# Insurance Information

**Name of Insurance Company:**_____

**Insurance Policy Holder's Name**:_____

**DOB:_____ Relationship to patient:_____**

**If policy holder is person other than yourself please complete the following:**

**Address:_____**

**City:_____ State:_____Zip Code:_____**

**Phone: (  )_____DOB:_____ Social Security #: _____**

# Consent

**AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature:_____ Date:_____

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.

Signature:_____ Date:_____

# Patient History

**Chief Complaint:_____**

**Medication Allergies:_____**

**Primary Care Doctor:_____ Referred by:_____**

# Current Medications

***Please feel free to use the back if needed***

| Regular Medications | Mg | # of times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Past Medical History

| Previous Surgeries | Surgeon/ Hospital | Year |
|---|---|---|
| | | |
| | | |
| | | |

**Head, Neck, or Back injuries: _____Date:_____**
**Other serious injuries: _____Date:_____**

**If MAJOR SYMPTOMS IS DUE TO INJURY ON JOB, PLEASE COMPLETE THE FOLLOWING**

**Date:_____ Place:_____**
**Describe accident:_____**
**Doctor consulted:_____**
**X-Rays taken (date & location):_____**
**First day out of work:_____ Amount of days absent:_____**
**Caseworker name:_____ Phone #: (___)_____**

# Past Medical History

Do you currently or have you previously experienced any of the following:

**Please write year of onset**

| | | | |
|---|---|---|---|
| Asthma | | High Blood Pressure | |
| Blood Disorder | | Kidney Disease | |

| | | | |
|---|---|---|---|
| Cancer | | Lung Cancer | |
| Chest Pain | | Unconsciousness | |
| Diabetes | | Venereal Disease | |
| Heart Disease | | Mental Disorder | |
| Stomach Ulcers | | Thyroid Disorder | |
| Hepatitis/ Jaundice | | | |

**Unusual Childhood illness:**_____
**Any other illness:**_____

# Family History

Do you have any blood relatives with the following:

| Problem | YES | NO | Relationship |
|---|---|---|---|
| Hearing Loss | | | |
| High Blood Pressure | | | |
| Heart Disease | | | |
| Stroke | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| Convulsion/ Epilepsy | | | |
| Cancer Type | | | |
| Birth Defect | | | |
| Type of defect | | | |
| Cleft Lip, ETC | | | |
| Type of cleft | | | |
| Other disease | | | |
| Type of disease | | | |

ENT Checklist

Name: _____ Date: _____

| Place a check mark next to the appropriate response to the listed symptoms | | | |
|---|---|---|---|
| **Ears:** | | | |
| Hearing loss | No ____ | Right Ear ____ | Left Ear____ |
| Ringing or other noise in the ear | No ____ | Right Ear ____ | Left Ear____ |
| Fullness or pressure in the ear | No ____ | Right Ear ____ | Left Ear____ |
| Ear Pain | No ____ | Right Ear ____ | Left Ear____ |
| Ear Drainage | No ____ | Right Ear ____ | Left Ear____ |
| Frequent Ear Infections | No ____ | Right Ear ____ | Left Ear____ |
| Spinning | No ____ | Yes ____ | |
| Off Balance | No ____ | Yes ____ | |
| Lightheaded | No ____ | Yes ____ | |
| **Nose/ Sinuses:** | | | |
| Facial Pain or pressure | No ____ | Right Side ____ | Left Side ____ |
| Nasal Obstruction | No ____ | Right Side ____ | Left Side ____ |
| Frequent Nose Bleeds | No ____ | Right Side ____ | Left Side ____ |
| Postnasal Drainage | No ____ | Yes ____ | |
| Excessive Sneezing | No ____ | Yes ____ | |
| **Upper Airway/ Throat:** | | | |
| Excessive Snoring | No ____ | Yes ____ | |
| Apnea (difficulty breathing when asleep | No ____ | Yes ____ | |
| Reflux (heartburn, indigestion) | No ____ | Yes ____ | |
| Frequent throat infections | No ____ | Yes ____ | |

**Dr. Robert W. Poe**
**Brunswick Ear, Nose and Throat**
**PO Box 11399**
**Southport, North Carolina 28461**
**(910)-457-0734** **(910)-457-9116**

## NOTICE OF PRIVACY PRACTICES RECEIPT

I ACKNOWLEDGE THAT I WAS PROVIDED WITH THE NOTICE OF PRIVACY PRACTICES OF THE MEDICAL PRACTICE NAMED AT THE TOP OF THIS PAGE.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____ Patient's Date of Birth _____

For Personal Representative of the Patient ( if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship: _____

Signature of Personal Representative: _____

Date: _____

Robert W. Poe, MD
Ear, Nose and Throat Specialist

**CONSENT FOR RELEASE OF INFORMATION**

Patient's full name _____

Patient's date of birth _____

I Hereby Authorize _____

TO RELEASE SPECIFIED INFORMATION IN MY RECORD TO:

Robert W. Poe MD
Brunswick Ear, Nose, and Throat
PO Box 11399
Southport, NC 28461
Phone# 910-457-0734
Fax # 910-457-9116

THIS DATA SHALL INCLUDE_____

_____ Date_____
(Signature of patient or responsible party, full name)

_____ Date_____
(Witness by Employee of Brunswick Ear, Nose, and Throat)