PATIENT INFORMATION

NAME:	DATE OF BIRTH:
ADDRESS ONE:	SOCIAL SECURITY #:
ADDRESS TWO:	SEX: PRIMARY LANGUAGE:
CITY:	RACE: ETHNICITY:
STATE: ZIP:	USUAL PROVIDER:
PRIMARY PHONE:	REFERRING PROVIDER:
WORK PHONE:	PRIMARY PROVIDER:
ALTERNATE PHONE:	LAST HIPAA SIGN:

GUARANTOR/EMERGENCY INFORMATION

NAME:	DATE OF BIRTH:
ADDRESS ONE:	SOCIAL SECURITY #:
ADDRESS TWO:	EMPLOYER:
CITY:	
STATE: ZIP:	EMERGENCY CONTACT:
PRIMARY PHONE:	EMERGENCY CONTACT PHONE #:
WORK PHONE:	
ALTERNATE PHONE:	

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INSURANCE:
CERTIFICATE #:	CERTIFICATE #:
GROUP #:	GROUP NUMBER:
GROUP NAME:	GROUP NAME:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:

_______ Authorization to Bill and Receive Payments: I authorize the release of medical or other information necessary to process health insurance slaims. I also request payment of benefits be made directly to my provider, when he/she accepts assignment.

______ Acknowledgement of Receipt of Privacy Notice: I have received and reviewed a copy of the Notice of Privacy Practices and Finncial Policy for the office of Northeast KS Facial Plastic, ENT and Pulmonology as of the date of my signature.

______ Email/Cell Authorization: Our doctors occasionally email other providers in coordination of you care. I am aware the email is not always secure and other parties may have acces t this information. We/our representatives may also contact you via cell phone if that is the number you have provided us.

_______ Authorization to Release Medical Information: I hereby authorize my provider or representatives to discuss my information with the person(s) identified below. I also understand any change or revocation of this will need to be submitted in writing.

X ________________________________ __________
Date

If there is anyone you would like to have access to your health/account information, please complete the information below:

_______________________________________ _______________________
Name of person authorized to receive information Relationship

_____Health information _____Billing information _____All information

Pharmacy________________

Personal History Form

Please Fill in the Following as Completely as Possible

Name ________________________________ Date ____________________________

Birthdate ____________________________ Referring Doctor _______________________

SSN _______________ AGE __________ Is there any other doctor we should send your office note to? __________________

Reason for Vistit ____

Meds
(list dose and frequency)
____
____
____
____
____
____
____

Drug Allergies
____
____
____
____
____
____
____
____

Smoke: No Quit____ Yes____ pks/day
Drink: No Moderate Daily
Other Tobacco: No Yes
Surgeries (with dates)
____
____
____
____
____

If you are 64 and older have you received a pneumonia vaccine? **Yes No**

Have you received the Flu Shot **THIS** year**? Yes No**

Health Maintenance: If you are a woman **age 40-69** have you had a mammogram in the past 2 years**? Yes No** If yes please list date ________________________________

If you are **age 50-74** have you had a Colonoscopy in the past 10 years, Flexible Sigmoidoscopy in the past 5 years, or Fecal Occult Blood Test in the past year? **Yes No** If yes please list date ____________

Please Circle If any of the following are YES

Immediate Family History
- Heart Disease
- Respiratory Disease
- Diabetes
- Bleeding Problems
- Hearing Loss
- Anesthesia Problems
- Cancer

Health Questions for Patient
- Weight Loss/Gain
- Chills
- Fever
- Dizziness
- Night Sweats
- Cough
- Heartburn
- Nasal Obstruction
- Indigestion
- Bleeding Problems
- Normal Development
- Up to Date on Shots
- Ringing in Ears
- Snoring
- Allergies
- Short of Breath
- Difficulty Breathing
- Wheezing
- Hearing Loss
- Joint/Muscle Pain
- Is patient in Daycare

Patient Medical History
- Congestive Heart Failure
- Diabetes
- High Blood Pressure
- Stroke
- Heart Attack
- Asthma
- Colorectal Cancer
- Breast Cancer
- Cancer other:
- COPD
- Pulmonary Fibrosis
- Sarcoidosis

Other Medical Problems ____