ENT & Allergy Specialists of VA Registration Form

Which provider are you seeing today? ○ Dr. James Lee ○ Dr. Vickie Lee ○Penelynne Flores, CFNP ○ Dr. Rachel Watson

PATIENT PERSONAL INFORMATION ***(please fill in all fields)***			
Please Print Clearly			
Last Name		Primary care Provider (PCP)	
First Name	MI	Referring Provider (if different than above)	
Previous Name (if any)		Date of Birth (mm/dd/yyyy)	
Address		Sex: M F (Circle one)	
City		Marital Status: Single Married Divorced Widow(er) (Circle one)	
State	Zip Code	Social Security Number	
Home Phone	Cellphone	Employer Name:	
Work phone	E-Mail	Employment status: (FT/PT)	Student status (Y/N)

INSURANCE POLICY HOLDER INFORMATION (GUARANTOR)			
○ **Same as above**			
Last Name	First Name		MI
Date of Birth (mm/dd/yyyy)		Social Security Number	
Home Phone		Email	
Mailing Address	City	State	Zip Code
Occupation		Name of Employer	
Employers Address	City	State	Zip Code
Emergency Contact	Phone #	Relation to Patient: Self Spouse Parent Other: specify	

PRIMARY INSURANCE INFORMATION		
Name of Insurance		Effective date of Coverage
Policy Number	Co-pay	Group Number / Group Name

SECONDARY INSURANCE INFORMATION		
Name of Insurance		Effective date of Coverage
Policy Number	Co-pay	Group Number / Group Name

PHARMACY INFORMATION (Please enter your preferred pharmacy where we should send your prescriptions-we will attempt to find it in our database.)		
Name:	City:	Street:

I hereby authorize ENT & Allergy Specialists of VA to apply for benefits on my behalf for services rendered. I requested payment from the above indicated insurance carrier to be made directly to ENT & Allergy Specialists of VA. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any medical records necessary, including information for this or any related claim to the carriers indicated above.

Signature:_____ Date _____/_____/_____

Name: _____ DOB:_____

PATIENT MEDICAL INTAKE FORM

PLEASE FILL IN THE APPROPRIATE CIRCLES (O), ie : ● Do not use ✘

PATIENT HISTORY

What is the REASON for the office visit? _____

Who referred you to our office/ How did you hear about us?_____

CURRENT MEDICATIONS: Are you taking any medications now? O **Yes** O **No**

If yes, please list **name/dosage/frequency/route** of the medicine. Include prescription, over the counter, natural, herbals:

Name of Medicine	Dosage	Frequency	Route	Prescribing physician/date

ALLERGIES: Are you allergic to any ***MEDICATIONS***? O **Yes** O **No**

If yes, please **list** the **medication(s)** and **reaction**?

Medication:_____Reaction:_____
Medication:_____Reaction:_____
Medication:_____Reaction:_____

SURGERIES: Have you ever had surgery(ies)? O **Yes** O **No** If yes, please state **type/date** below

Date of Surgery (approximate date)	**Type of Surgery**

Have you ever been ***HOSPITALIZED?*** O **Yes** O **No** O **For Above Surgery(ies)**

If yes, please state **cause** and **when?**_____

Have you ever had an ***ALLERGY TEST***? O **Yes** O **No** O **I don't know**

If yes, please state **where** and **when?** _____Date:___/____/___

Have you ever had a ***HEARING TEST***? O **Yes** O **No** O **I don't know**

If yes, please state **when** and **where**? _____

Did it show a hearing loss? O **Yes** O **No** O **I don't know**

If female, are you (or could you be) ***PREGNANT***? O **Yes** O **No**

Name: _____ DOB:_____

Please fill in each appropriate circle (O) completely: example ● (Do not mark with X)

PAST MEDICAL HISTORY:

Have you ever been diagnosed with any of the following? If yes, please **mark** the following:

O Acid Reflux	O COPD/Emphysema	O Hearing Loss	O Hives
O Allergic Rhinitis	O Depression	O Heart Attack	O Immunodeficiency
O Anxiety Disorder	O Deviated Septum	O Heart Disease What type?	O Sleep Apnea
O Asthma	O Diabetes	O Hepatitis	O Thyroid Disease
O Bleeding Disorder	O Ear Infections	O High Blood Pressure	O TMJ Disease
O Cancer What type? _____	O Eczema	O High Cholesterol	O Tonsillitis
O Chronic Sinusitis	O Headaches	O HIV/AIDS	

O Other: _____

O Other: _____

FAMILY HISTORY

Father:	O Alive	O Deceased	O Healthy	Medical problems: O Diabetes O High Blood Pressure O Stroke O Heart Attack O Mental Illness O Cancer
Mother:	O Alive	O Deceased	O Healthy	Medical problems: O Diabetes O High Blood Pressure O Stroke O Heart Attack O Mental Illness O Cancer

# of Son(s):	O None O 1 O 2 O 3 O 4 O 5
# of Daughter(s):	O None O 1 O 2 O 3 O 4 O 5

SOCIAL HISTORY

OCCUPATION: What is your occupation? _____

O **Full-time** O **Part-time** O **Student** O **Not employed** O **Retired**

CAFFEINE: Do you drink caffeine? O **Yes** O **No** **Cups per day?** O 1 or less O 2-4 O >4

PETS: Do you have pets in the home? O **Yes** O **No** O Dog O Cat O Bird O Other:

SMOKING: Do you smoke cigarettes? O **Yes** O **No # Packs/day?** O 1/2pk O 1pk O >1-2pks

CHEWING TOBACCO: Do you chew tobacco? O **Yes** O **No**

ALCOHOL: Do you consume alcohol? O **Yes** O **No Drinks per week?** O 1 or less O 2-4 O >4

DRUGS: Do you use any recreational drugs? O **Yes** O **No** **List:**

HOBBIES: Are you active with hobbies? O **Yes** O **No** **Type of hobby?**

EXERCISE: Do you exercise? O **Yes** O **No** **How often?** O Once a wk O 2-4d/wk O >5d/wk

HOME LIVING SITUATION? O **Alone** O **w/ Spouse** O **w/Spouse & Kids** O **w/Kids** O **Other:_____**

Name: _____ DOB:_____

PATIENT REVIEW OF SYSTEMS						
Please indicate if you've had any of the below symptoms: ***Please fill in each appropriate circle (O) completely: example ● (Do not mark with X)***						
Allergy	Medication:	Yes O	No O	Bee Venom:	Yes O	No O
	Pollens:	Yes O	No O	Vaccination:	Yes O	No O
	Foods:	Yes O	No O	Latex:	Yes O	No O
Cardiology	Catherization:	Yes O	No O	High Blood Pressure:	Yes O	No O
	Chest Pain:	Yes O	No O	High Cholesterol:	Yes O	No O
	Bypass surgery:	Yes O	No O	Blood thinners:	Yes O	No O
	Palpitations:	Yes O	No O			
Dermatology	Hives:	Yes O	No O	Eczema/Itchy skin:	Yes O	No O
	Rash:	Yes O	No O			
Endocrine	Weight Gain/Loss:	Yes O	No O	Cold/Heat Intolerance:	Yes O	No O
				Insomnia:	Yes O	No O
ENT	Nose bleeds:	Yes O	No O	Sinus pain:	Yes O	No O
	Voice Change:	Yes O	No O	Hearing loss:	Yes O	No O
	Cough:	Yes O	No O	Nasal congestion:	Yes O	No O
	Ringing in ears:	Yes O	No O	Sore throat:	Yes O	No O
Gastrointestinal	Constipation:	Yes O	No O	Nausea:	Yes O	No O
	Diarrhea:	Yes O	No O	Abdominal Pain:	Yes O	No O
	Heartburn:	Yes O	No O	Difficulty swallowing:	Yes O	No O
	Vomiting:	Yes O	No O			
Musculoskeletal	Carpal tunnel:	Yes O	No O	Back pain:	Yes O	No O
	Neck pain:	Yes O	No O	Joint pain:	Yes O	No O
Neurological	Headache:	Yes O	No O	Stroke:	Yes O	No O
	Seizures:	Yes O	No O	Insomnia:	Yes O	No O
	Tingling/numbness:	Yes O	No O			
Psychiatric	Depression:	Yes O	No O	Mood swings:	Yes O	No O
	Anxiety:	Yes O	No O	High stress level:	Yes O	No O
Respiratory	Chest Tightness:	Yes O	No O	Shortness of Breath:	Yes O	No O
	Wheezing:	Yes O	No O			

ENT & ALLERGY SPECIALISTS OF VIRGINIA
44320 Premier Plaza, Suite #110 Ashburn VA 20147
703-723-8727(P) 703-723-9787(F)

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address:

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature: _____

Date: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other: _____

Prepared By: _____

Signature: _____

Date: _____

3/31/16