FAIRFAX ENT &
FACIAL PLASTIC SURGERY

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Otolaryngology-Head and Neck Surgery • Facial Plastic Surgery

Welcome to our office. Please complete these forms as completely and accurately as possible.

TODAY'S DATE:

PATIENT INFORMATION

Patient's Last Name | First Name | Middle Initial

Parent Name (if Patient is a minor)

Patient Age | Date of Birth | Sex: ☐ Male ☐ Female | Social Security Number

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Address | City | State | Zip

Primary Phone | Secondary Phone | Other Phone

E-Mail Address

Your Occupation | Your Employer

Spouse Name | Spouse's Employer

Whom May We Thank for Referring You to Our Practice?

NOTIFY IN CASE OF EMERGENCY

Name | Relationship

Home Phone | Work Phone | Cellular Phone

Nearest Relative (not living with you)

Home Phone | Work Phone | Cellular Phone

WHO IS YOUR DOCTOR? (PRIMARY CARE AND SPECIALIST)

Physician Name	Specialty	Address

Signature : _____ **Date**: _____
Signature : _____ **Date**: _____
Signature : _____ **Date**: _____
Signature : _____ **Date**: _____

PRIMARY INSURANCE

Primary Insurance Name		Telephone Number	
Claim Address	City	State	Zip
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Number
Insurance ID	Group #		

SECONDARY INSURANCE

Secondary Insurance Name		Telephone Number	
Claim Address	City	State	Zip
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Number
Insurance ID	Group #		

MY PHARMACY

Pharmacy Name	Location	Phone Number

PATIENT RESPONSIBILITY

Please read our Financial Policy Statement and Agreement and sign below.

Medical Records
I authorize the use of this form on all my insurance submissions. I authorize the release of my medical information to all my insurance companies if they so request.

Payment and Collections
I understand that payment is due at the time of service. I understand that I am personally responsible for any and all costs not covered by my insurance. I understand that if my account is turned over to collection that I will be responsible for 33 1/3% attorney fees, court costs, search costs and 18% annual interest on unpaid balances.

Insurance Payments
I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor. I understand it is my responsibility to notify and update the office if my insurance or address or phone information changes.

Insurance Denial of Payment because not "Medically Necessary"
I agree to accept responsibility for payment in full for any charges for services requested by me and rendered that are denied by my insurance because the insurance company deems the service to be not "medically necessary".

Cancellation Policy and Fees
I understand that 24-hour notice is required to cancel all appointments and that if sufficient notice is not given, then a **no-show fee** will be charged to my account and this will not be covered by my insurance. The no-show fee is **$50** for office visits and **$150** for procedures, allergy testing and audiology appointments.

Signature : _____**Date**:_____

Name:

MEDICAL HISTORY

What is the reason for your visit?
How long have you had the problem?
How severe is the problem?
Prior treatments….

WHAT MEDICAL PROBLEMS DO YOU HAVE?

NO	YES	PROBLEM	DATE / DETAILS
		Major Illness	
		Major Injury	
		Hospitalization	
		Acid Reflux	
		Anemia	
		Asthma	
		Bleeding / Bruising Problems	
		Blood Clots	
		Cancer	
		Diabetes	
		Heart Problems	
		High Blood Pressure	
		Kidney Problems	
		Liver Problems	
		Lung Problems	
		Thyroid Problems	
		CHILDREN ONLY	
		Born Premature	
		Congenital Defects	
		Reading/Learning Disability	
		WOMEN ONLY	
		Are you pregnant?	

Name**:**

WHAT SURGERIES HAVE YOU HAD?

NO	YES	PROCEDURE NAME	DATE	SURGEON / LOCATION
		Tonsillectomy		
		Adenoidectomy		
		Ear Surgery		
		Nose Surgery		
		Throat/Neck Surgery		
		Anesthesia Problems		
		OTHER *Please list…*		

PLEASE LIST ALL OF YOUR MEDICATIONS

☐ **NONE (include over the counter medications)**

	NAME / DOSE
Antacids/ Heartburn Meds	
Antibiotics	
Aspirin	
Birth control pills	
Blood pressure pills	
Beta Blockers	
Blood thinner	
Diabetes pills	
Pain pills	
Tranquilizers	
Vitamin E	
Water pills	

ARE YOU ALLERGIC TO ANY MEDICATIONS?

☐ **Yes** ☐ **NO**

NAME OF DRUG	REACTION (e.g. Hives, Wheezing, Anaphylaxis…)

Name:

SOCIAL HISTORY / HABITS / RISK FACTORS

NO	YES	QUESTION	DETAILS
		Tobacco:	
		Cigarettes	No packs/day:
		Cigars / Pipe / Chewing Tobacco	Quantity:
		Have you ever smoked in the past?	Date started: Date stopped:
		Alcohol:	☐Never ☐Rarely ☐Socially ☐Daily ☐Alcoholic
		Beer / Wine / Liquor	
		Drugs:	
		Cocaine / Marijuana / _____	
		Family:	
Children			Number: Ages:
Occupation			

FAMILY HISTORY

NO	YES	PROBLEM	RELATION	YEAR	*FOR DOCTOR NOTES*
		Allergies			
		Asthma			
		Arthritis			
		Bleeding problems			
		Cancer			
		Diabetes			
		Heart Trouble			
		Mental Illness			
		Migraine headaches			
		Stroke			
		Thyroid Disease / Goiter			
		Tuberculosis			
		Ear Infections			
		Otosclerosis			
		Glaucoma			
		Hearing Loss			
		Other: please list:			

DO YOU HAVE TROUBLE HEARING?

No	Yes	
		Do you have trouble hearing in noisy environments?
		Does anyone ever complain about your hearing?
		Do you use or own hearing aids?
		Have you ever been told that you would benefit from hearing aids?

Name:

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

NO	YES		NO	YES	
		CONSTITUTIONAL			**GASTROINTESTINAL**
		Weight Loss or Gain			Nausea/Vomiting
		Fatigue			Heartburn
		Fever/ Chills			Bowel Changes
		VOICE AND THROAT			Abdominal Pain
		Change in Voice			**CARDIOVASCULAR**
		Trouble Swallowing			Chest Pain
		Sore Throat			Leg Swelling
		EARS			**URINARY / REPRODUCTIVE**
		Hearing Loss			Do you think you could be pregnant now?
		Ringing or ear noise			Difficulty urinating
		Pain in ears			**MUSCULOSKELETAL**
		Dizziness/Imbalance			Pain in Neck
		MOUTH AND NECK			Stiff Joints
		Lumps in neck			**PSYCHIATRIC / EMOTIONAL**
		Headaches			Anxiety
		Nosebleeds			Depression
		EYES			**NEUROLOGIC**
		Blurred Vision			Numbness
		Double Vision			Weakness/Paralysis
		RESPIRATORY			Tingling
		Cough			Difficulty Walking
		Wheezing			**Skin**
		Shortness of Breath			Itching/ Rash
		Coughing up Blood			Non healing lesion
		ENDOCRINE / METABOLIC			**Hematological**
		Heat or Cold Intolerance			Bleeding or Bruising
		Hair Change			Enlarged Lymph Nodes

Reviewed by Patient:

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

Signature: _____ . Date: _____ .

SUBMIT

PHYSICIAN: I have reviewed the PMH, SH, FH and ROS