FAIRFAX ENT &
FACIAL PLASTIC SURGERY

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E-MAIL
SAVE
PRINT

Welcome to our office. Please complete these forms as completely and accurately as possible.
We recommend saving the completed file first then e-mail using the e-mail button. The e-mail function however in some browsers doe not function optimally. In that case, please just e-mail the saved file to info@fairfaxent.com. Thanks!

**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: _____ .

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

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