PATIENT INFORMATION

Name of Patient _____ ☐ Male ☐ Female Date _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Social Security No _____

Employer _____

Name of ☐ Mother ☐ Father or ☐ Spouse _____ Phone _____

Employer of ☐ Mother ☐ Father or ☐ Spouse _____ Phone _____

Reason for Visit: _____

INSURANCE INFORMATION

Name of Insurance Co _____ Name of Subscriber _____

Subscriber's Date of Birth _____ Subscriber's Social Security No _____

Subscriber's Employer _____ Employer's Phone _____

Relationship of Subscriber to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other _____

Primary Doctor _____ Address _____ Phone _____

(First Name Last Name) _____

Please CHECK one or more in each category:

Race:

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Refused to report

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Refused to report

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Italian
- ☐ Arabic
- ☐ Greek
- ☐ Hindu
- ☐ Russian
- ☐ Refused to report

Patient Name _____ Date of Birth _____ Date _____

PATIENT'S MEDICAL HISTORY

Do you have any of the following?

Past blood transfusions	☐ Yes	☐ No		Heart disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		High blood pressure	☐ Yes	☐ No	
Hypoglycemia	☐ Yes	☐ No		Thyroid problems	☐ Yes	☐ No	
Liver disease/jaundice	☐ Yes	☐ No		Hepatitis	☐ Yes	☐ No	
History of tuberculosis	☐ Yes	☐ No		Bleeding problems	☐ Yes	☐ No	
History of kidney stones	☐ Yes	☐ No		History of cancer	☐ Yes	☐ No	

Other Medical Conditions: _____

Medication Allergies: _____

Other Allergies: _____

Previous surgical procedures: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication/Dose and Quantity	Medication/Dose and Quantity	**Pharmacy/Address and Phone**

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Cigars ☐ Pipe

How many cigarettes per day _____ How many cigars per day _____

Have you ever smoked? ☐ Yes ☐ No

How long have you or did you smoke? _____ How many cigars per day _____

Do you consume alcohol? ☐ Yes ☐ No

"I drink ____ beers, ____ Glasses of wine, ____ Drinks of hard liquor per ☐ day ☐ week ☐ month."

History of IV drug abuse or other HIV/AIDS risk factors: _____

EMERGENCY CONTACT: _____ Relationship: _____

Home Phone of Emergency Contact: _____ Cell Phone: _____

FAMILY HISTORY: (Parents and Grandparents):

Heart disease	☐ Yes	☐ No		Stroke	☐ Yes	☐ No	
High cholesterol	☐ Yes	☐ No		Cancer	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No		Diabetes	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No		Asthma	☐ Yes	☐ No	

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Patient Name _____ Date of Birth _____ Date _____

General

Good general health	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Skin

Change in wart/mole	☐ Yes	☐ No
Change in hair	☐ Yes	☐ No
Change in skin	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Nail changes	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Eyes

Eye disease or injury	☐ Yes	☐ No
Wear glasses/contacts	☐ Yes	☐ No
Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No

Respiratory

Chronic cough	☐ Yes	☐ No
Bloody sputum	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Snoring	☐ Yes	☐ No

Cardiovascular

Heart trouble	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No
Swelling feet, ankles, hands	☐ Yes	☐ No

Gastrointestinal

Indigestion	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Acid taste in throat	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Change in bowel movement	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Pain with bowel movement	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No

Neurology

Headaches	☐ Yes	☐ No
Light headed	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Convulsions/Seizures	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Endocrine

Glandular/hormone problem	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Excessive urination	☐ Yes	☐ No
Heat intolerance	☐ Yes	☐ No
Cold intolerance	☐ Yes	☐ No
Skin becoming dryer	☐ Yes	☐ No

Hematologic/Lymphatic

Slow to heal	☐ Yes	☐ No
Bleeding/bruising easily	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Notes

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North Oakland ENT Policies and Procedures

Patient Name _____ Date of Birth _____ Date _____

Name of another individual we may discuss your appointment, treatment, test results and billing.

Name: _____ Phone: _____

Relation to Patient: _____

May we leave a message: at home ☐ Yes ☐ No
at work ☐ Yes ☐ No
on cell ☐ Yes ☐ No

Your insurance is a contract between you, your employer and the insurance company. We are not party to the contract. Not all services are covered in all contacts. Some insurance companies arbitrarily select certain services that will not be covered. We are not responsible to know your deductibles and co pays. If you have questions in regards to your insurance just ask and we may be able to help. If we cannot help you, we will direct you to contact your insurance company.

Any unpaid balances need to be paid in full prior to any surgeries or procedures being performed.

There will be a $25 no show fee for any appointment not canceled within 24 hours of the appointment.

Payment plans are used in extreme cases and the payment plan must be 25% of the balance per month.

After 3 statements with no response or payment your account will automatically go to collection.

I authorize Dr Carl B. Shermetaro, Dr Gary S. Kwartowitz and/or Dr. Asha Downs to treat me as they deem necessary. I authorize them to bill my insurance company. I understand I will be responsible for any co-pay, deductible and/or fee for any non-covered services at the time service is rendered.

If my insurance company requires a referral and I do not have one I am responsible for all charges.

It is our policy; the person who brings a child in is responsible for payment at the time the service is rendered and any reimbursement from divorce agreements be handled by that person and not by our office.

We cannot see anyone under 18 without a parent or guardian. If a patient is not with parent or guardian, we need a signed agreement and a copy of a picture ID from the parent or guardian.

I have read and understand all of the above.

_____ _____

Signature of Patient or Responsible Party Date