

**Patient Information & Medical History Form  
NORTHEAST EAR NOSE AND THROAT**

**299 Faunce Corner Road, North Dartmouth, MA 02747  
191 Bedford Street, Fall River, MA 02720**

**TEL (508) 995-0700  
TEL (508) 674-1180**

**FAX (508) 995-3070  
FAX (508) 674-1189**

\_\_\_\_\_  
Name Date of Birth Age

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Home Phone Cell Phone E-mail Address

\_\_\_\_\_  
Social Security # Marital Status Primary Care Physician

\_\_\_\_\_  
Pharmacy Used Telephone #

\_\_\_\_\_  
Employer Occupation Work Phone

\_\_\_\_\_  
Emergency Notification of Kin (Name & relationship) Best Phone #

**Insurance Information**

\_\_\_\_\_  
Primary Insurance Primary Insurance Number

\_\_\_\_\_  
Secondary Insurance Secondary Insurance Number

\_\_\_\_\_  
Medicare Part D Number

**Who is Responsible for Your Insurance?**

\_\_\_\_\_  
Subscriber's Name Relationship to Patient D O B

**Reason for Your Visit?** \_\_\_\_\_

**Who Referred You to This Practice?** \_\_\_\_\_

**Past Medical History** Please Check "yes" or "no". If "yes", please explain.

	<b>Yes</b>	<b>No</b>	<b>Please explain:</b>
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Lung Disorders/Asthma	_____	_____	_____
Liver Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Neurological Disorders	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disorder	_____	_____	_____
HIV	_____	_____	_____
Other	_____	_____	_____

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

**Past Surgical History** Please list your previous surgeries below:

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**Medications** Please list all, including herbal/homeopathic medications below:

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**Allergies to Medication** Please list medications and reactions (eg. itching, hives)

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Do you smoke? \_\_\_Yes \_\_\_No How much and for how many years? \_\_\_\_\_

If No, did you smoke previously? \_\_\_Yes \_\_\_No How much and for how many years? \_\_\_\_\_

How often do you drink alcohol and what amount? \_\_\_\_\_

Drug use? \_\_\_\_\_Yes \_\_\_\_\_No

Any history of bleeding disorders? \_\_\_\_\_Yes \_\_\_\_\_No

Any History of Anesthesia reactions? \_\_\_\_\_Yes \_\_\_\_\_No

**Please Circle Y or N:**

Cough	Y	N	Headaches	Y	N
Chest Pain	Y	N	Short of Breath	Y	N
Asthma	Y	N	Palpitations	Y	N
Weight Loss	Y	N	Anemia	Y	N
Weight Gain	Y	N	Easy Bruising	Y	N
Fevers	Y	N	Rash	Y	N
Night sweats	Y	N	Heartburn/Reflux	Y	N
Other					

**Family History** Do you have any family members with the following illnesses?

	Yes	No	Please explain:
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Lung Disorders/Asthma	_____	_____	_____
Liver Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Neurological Disorders	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disorder	_____	_____	_____

**BY SIGNING THIS FORM, I ATTEST THAT THE ABOVE MEDICAL INFORMATION IS ACCURATE, AND I HAVE DISCLOSED ALL INFORMATION HONESTLY. I ALSO HEREBY AGREE TO ACCEPT FULL RESPONSIBILITY FOR CHARGES INCURRED.**

**RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS:**

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

**Patient or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Reviewed:** \_\_\_\_\_ **Date:** \_\_\_\_\_