ENT Physicians and Surgeons of Charleston

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ **First** _____ **MI** _____

Address: _____

SSN: _____ **Email:** _____

Primary Phone: _____ **Cell Phone:** _____ **Emergency Contact:** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____ **Marital Status:** *Single / Married / Divorced / Widowed*

Race: _____ **Ethnicity:** *Hispanic / non-Hispanic /decline to state* **Preferred Language:** *English / Spanish / Other* _____

Employer: _____ **Employer Phone:** _____ **Occupation:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy (include location and phone #): _____

Height_____**Weight**_____ **REASON FOR TODAY'S VISIT:** _____

Primary Ins: _____ **Name of Insured:** _____ **DOB:**_____ **Insured SSN:** _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: Please use back for additional medications

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ **Yes** ____ **No.** If yes, please list below:

Name of Medication allergy	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: _____

List any surgeries you have had (including dates):

_____

_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations _____

Privacy: May we call your phone? *Y / N* May we send communications to your home? *Y / N* May we contact you at work? *Y / N*
Whom else may we speak to about your care if you are not available? _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from ENT Physicians and Surgeons of Charleston whether covered by insurance or not.

Patients Signature: _____ **Date:**_____