DATE:_____

Loudoun ENT Specialists

46090 Lake Center Plaza #104
Sterling, VA 20165
(703) 421-1700 phone (703) 421-5550 fax
www.entofloudoun.com

Patient Name:_____ Date of Birth: _____ Sex: Male Female

(Last) (First) (Middle) **Preferred Name:**_____

Patient Address:_____ City:_____ State: _____ Zipcode: _____

Home Telephone #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Email:_____ Emergency Contact name and phone #_____

Preferred method of communication: (circle one) Home phone Cell phone Work phone Email

Parent or Guardian (if patient is under 18)_____

Primary Care Physician: _____ Did your primary refer you?_____

Referring Physician: (First and Last name): _____

Whom shall we thank for referring you? (circle one) *Physician Family/Friend Insurance Internet Search Yellow Pages Website Social media Direct mail*

INSURANCE INFORMATION

Primary Insurance Company Name:_____ HMO_____ PPO _____ POS _____

Policy/ID#_____ Group #_____

Policy Holder Name:_____ Date of Birth: _____

Secondary Insurance Company Name:_____ HMO_____ PPO _____ POS _____

Policy/ID#_____ Group #_____

Policy Holder Name:_____ Date of Birth: _____

PLEASE HAVE A COPY OF YOUR INSURANCE CARD AND PHOTO ID

I certify that all the information provided on the form is accurate to the best of my knowledge. I have read and understand the Authorization to *Release Information and the Benefit Assignment to Loudoun ENT Specialists.*

_____ x_____

Please print patient's full name Patient's signature

PLEASE READ AND INITIAL THE FOLLOWING FOR LOUDOUN ENT SPECIALISTS:

_____ **Cancellation Policy**: We reserve the right to charge a missed appointment fee of $75 for appointments cancelled or missed without 24 hours' notice.

_____ **Copayment, Deductible, Coinsurance**: We collect all patient financial responsibility at the time of your visit. This information is gathered directly from insurance information provided by you.

_____ **Eligibility and Benefit Verification**: We attempt to verify all insurance information prior to your arrival. We invite you to also familiarize yourself with your plan benefits and restrictions. We have no leverage with your insurance company on what procedures are paid and at what rates.

_____ **Referrals**: If your insurance plan requires a referral from a primary care provider, it is **your responsibility** to obtain and provide that information to Loudoun ENT Specialists. Noncompliance may result in additional fees.

_____ **Out-of-Network**: Your insurance plan may provide out-of-network coverage. We will provide you with the necessary paperwork to be reimbursed directly.

_____ **Divorced/Separated Parents of Minors**: The parent who consents to treatment of a minor child is responsible for payment of services rendered. Loudoun ENT Specialists will not be involved with separation or divorce issues.

PAYMENT IS DUE AT TIME OF SERVICE

HIPAA Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the Commonwealth of Virginia. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

X _____

Patient Signature/Date

I grant access to my personal health information to the following:

_____

_____

_____

Loudoun ENT Specialists
46090 Lake Center Plaza, Suite 104
Sterling, VA 20165

ENT Health History – New Patient / Consult

*Please complete this **ENT specific history** to help us meet your ENT needs. It is an integral part of your healthcare.*

Date: _____

Patient Name_____ DOB_____ Male / Female Height _____ Weight _____

Occupation_____ Pharmacy Name/Address_____Primary Care Physician_____

Who referred or recommended you see ENT? ☐Doctor_____ ☐Self ☐Friend_____ ☐Google ☐Other_____

Have you ever seen ENT before? ☐No ☐Yes (Name of ENT or ENT Practice_____)

Main Reason for today's ENT *or* Audiology Consult (include any current treatment or medications including over-the-counter):

_____

_____

Have you been seen elsewhere for this condition? ☐Yes ☐ No

If **yes**, please indicate date, location, treating physician/provider (*please complete ALL that apply*):

☐PCP(*listed above*) ☐Referring (*listed above*) ☐Urgent Care/ER(_____) ☐ENT(_____) ☐Other (_____)

Previous treatment for this condition *(including ALL prescription and/or OTC medications)*:_____

Previous imaging for this condition: ☐No ☐Yes(Type of study:_____ When/where was it done?_____)

MEDICATIONS CURRENTLY TAKING: *(include aspirin, vitamins, over-the-counter or herbal medications)* ☐ **NONE**

Medication Name	Reason for taking this medication	Dose	How often taken

DRUG ALLERGIES / MEDICAL ALLERGIES: ☐ **NONE**

Medication you are allergic to	Type of Reaction

Latex Allergy: ☐Yes ☐No

SURGICAL HISTORY: ☐NO PREVIOUS SURGERY (*skip ahead to Social History if you have NO surgical history)*

ENT Surgeries:	Date(s)	Physician/Location
☐ Ear tubes	_____	_____
☐ Ear surgery:_____	_____	_____
☐ Nasal surgery:_____	_____	_____
☐ Sinus surgery:_____	_____	_____
☐ Tonsillectomy and/or Adenoidectomy (circle)	_____	_____
☐ Other ENT Surgery:_____	_____	_____
NON-ENT Surgeries: (Include ALL other surgeries you have had)		
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____

Have you had any problems/complications with surgery or anesthesia in the past? ☐No ☐Yes (Explain:_____)

Patient Name:_____

SOCIAL HISTORY:

Smoke cigarettes / Vape? ☐Never ☐Former x ____ years. Year quit:_____) ☐Active(___packs per day x _____years)

Exposed to second hand smoke? ☐Yes ☐No

Chew Tobacco? ☐Never ☐Former(x _____years. Year quit:_____) ☐Active(x _____ years)

Current Dentist: _____ At least twice yearly dental visits/oral cancer screenings with dentist? ☐Yes ☐No

Alcohol? ☐Never ☐Social(how often_____) ☐Regular(_____ per day or _____ per week) ☐History of binge drinking

Caffeine Use? ☐Never ☐Occasional ☐Regular(_____ per day or _____ per week)

Recreational drug use? ☐Yes(Type:_____ Frequency:_____) ☐No

Overuse/abuse of pain medication or controlled substance? ☐Never ☐Former(Year quit:_____) ☐Current(Type:_____)

Pets in the home: ☐Yes(Type:_____ Number of years present:_____) ☐No

How long have you lived in this area?_____ Where did you live previously?_____

FAMILY HISTORY: ☐None ☐Unknown ☐Adopted

	Relationship	Details / Additional Comments
o Alcoholism / Substance Abuse		
o Asthma		
o Allergic Rhinitis		
o Diabetes (☐Type 1 ☐Type 2)		
o High Blood Pressure		
o High Cholesterol		
o Hearing Loss (☐"age related" ☐congenital ☐unknown		
o Heart Disease		
o Migraines		
o Thyroid Disease		
o Cancer (Type(s):_____)		
o Other:_____		

Review of Systems: (Check any **CURRENT symptoms** *or* symptoms that you have had within past 6 months)

Constitutional ☐ No complaints
- o Fatigue
- o Fever / chills
- o Weight loss / weight gain
- o Loss of appetite
- o Pregnant / possibly pregnant
- o Other_____

Eyes ☐No complaints
- o Double vision
- o Itchy / dry eye
- o Eye pain
- o Blurry vision / visual changes
- o Discharge from eye
- o Excessive tearing
- o Other_____

Ears ☐ No complaints
- o Hearing loss: sudden or chronic
- o Difficulty hearing
- o Ear pain
- o Vertigo defined as "room spinning"
- o Ringing / tinnitus ears
- o Ear pressure / "trouble clearing"
- o Ear fullness/popping
- o Ear drainage / discharge
- o Itching in ear
- o Other_____

Nose ☐ No complaints
- o Frequent nosebleeds
- o Nasal congestion
- o Runny nose
- o "blocked" nose / nasal obstruction
- o Sinus pressure / fullness / pain
- o Other_____

Mouth / Throat ☐ No complaints
- o Sore throat
- o Bleeding gums
- o Snoring
- o Dry mouth
- o Mouth ulcers
- o Dental problems
- o Difficulty swallowing
- o Post nasal drip
- o Lump sensation in throat
- o Hoarseness / change in voice
- o Decreased sense of taste
- o Other_____

Sinus ☐ No complaints
- o Discolored nasal drainage / post nasal
- o Nasal obstruction / mouth breathing
- o Facial pain / pressure / fullness
- o Decreased sense of smell

Patient Name:_____

Neurologic ☐ No complaints

- Fainting / loss of consciousness
- Frequent headaches / migraines
- Seizures / tremors
- Numbness / tingling
- Weakness
- Migraines
- Restless legs
- Memory / concentration problem
- Other_____

Cardiovascular ☐ No complaints

- Chest pain
- Murmur
- Difficulty breathing with exertion
- Palpitations / rapid heart beat
- Edema / leg swelling
- Light headed on standing
- Other_____
-

Respiratory ☐ No complaints

- Wheezing
- Shortness of breath
- Blood in phlegm (hemoptysis)
- Sputum "phlegm" production
- Cough
- Sleep apnea
- Other_____

Gastrointestinal ☐ No complaints

- Vomiting / nausea
- Painful swallowing
- GERD "acid reflux" / "heartburn"
- Decreased appetite
- Diarrhea / constipation
- Other_____

Hematologic/Lymphatic ☐ No complaints

- Swollen glands
- Abnormal bruising
- Abnormal bleeding
- Enlarged/swollen lymph nodes
- Lightheadedness / "feeling faint"
- Mass or lesion:_____
- Other_____

Psychiatric ☐ No complaints

- Depression
- Anxiety
- Difficulty sleeping / restless
- Suicidal / Homicidal thoughts
- Other_____

Musculoskeletal ☐ No complaints

- Muscle aches / weakness
- Joint pain / arthralgias
- Other_____

Skin ☐ No complaints

- Rash
- Itchy / dry skin
- New growth/lesion:_____
- Other_____

Endocrine ☐ No complaints

- Increased thirst / increased hunger
- Hair loss
- Intolerance to heat / cold
- Other_____

Allergic / Immunologic ☐ No complaints

- Sneezing
- Runny nose
- Other_____

Genitourinary ☐ No complaints

- Difficulty urinating
- Pain with urination
- Urinary retention
- Urinary incontinence
- Blood in urine (hematuria)
- Urinary Frequency
- Loss of urinary control
- Other_____

Patient Name:_____

PAST MEDICAL HISTORY: (Check all that apply: © if currently active problem)

Ear/Nose/Throat ☐ No significant medical history

- o © Cholesteatoma
- o © Ear infections (chronic / recurrent)
- o © Benign Positional Vertigo (BPPV)
- o © Hearing loss
- o © Meniere's Disease
- o © Tinnitus
- o © Deviated Nasal Septum
- o © Nasal fracture
- o © Nasal polyps
- o © Nose bleeds (chronic)
- o © Nasal cautery
- o © Obstructive sleep apnea
- o © CPAP? Previous Current
- o © Rhinitis / non-allergic / "vasomotor"
- o © Adenoid Hypertrophy
- o © Cyst / Abscess
- o © Laryngitis (chronic)
- o © Pharyngitis (chronic)
- o © Sialadenitis
- o © Sinusitis (recurrent / persistent / chronic)
- o © Strep throat (recurrent / frequent)
- o © TMJ
- o © Tonsillitis (chronic)
- o © Vocal Cord Nodule
- o © Other_____

Neuro/Psych ☐ No significant medical history

- o © Neurologist:_____
- o © Psychiatrist:_____
- o © Balance issues
- o © Headaches / migraines
- o © Previous MRI brain:_____
- o © Anxiety
- o © Depression
- o © Other:_____

Cardiovascular ☐ No significant medical history

- o © Cardiologist:_____
- o © Cardiovascular Disease
- o © Congenital Heart disease
- o © Elevated cholesterol
- o © High blood pressure (Hypertension)
- o © History of Heart Attack
- o © Heart Murmur
- o © Palpitations
- o © Stroke (CVA) or TIA
- o © Pacemaker
- o © Other_____

Respiratory ☐ No significant medical history

- o © Pulmonologist:_____
- o © Asthma
- o © Chronic cough/bronchitis/COPD/Emphysema
- o © Cystic Fibrosis
- o © History of Pneumonia
- o © History of Tuberculosis
- o © Other_____

Muskuloskeletal ☐ No significant medical history

- o © Arthritis (OA or RA)
- o © Fibromyalgia
- o © Osteoporosis
- o © Other_____

Digestive ☐ No significant medical history

- o © Gastroenterologist:_____
- o © Reflux (GERD) / "heartburn"
- o © Inflammatory Bowel Disease (UC or Crohn's)
- o © Celiac Disease
- o © Hepatitis(Type:_____)
- o © Other_____

Endocrine ☐ No significant medical history

- o © Autoimmune disorder (Lupus, other:_____)
- o © Chronic Fatigue Syndrome
- o © Diabetes (Type 1 or Type 2)
- o © Hypothyroidism (thyroid deficiency)
- o © Hyperthyroid (thyroid excess)
- o © Renal Failure
- o © Vitamin Deficiency
- o © Other_____

Allergy/Immune ☐ No significant medical history

- o © Allergist:_____
- o © Allergic rhinitis *(Circle all known allergens below:)*
- o © Grasses, trees, weeds, molds, dust, cat, dog
- o © Food allergy (Type:_____)
- o © History of anaphylaxis:_____
- o © Immunodeficiency
- o © HIV / AIDS
- o © Other_____

Dermatology ☐ No significant medical history

- o © Dermatologist:_____
- o © Dermatitis (Eczema) / Psoriasis
- o © Dermatographism ("skin writing")

Heme/Cancer ☐ No significant medical history

- o © Hematologist / Oncologist:_____
- o © Anemia / bleeding / clotting disorder / DVT/ PE
- o © History of cancer (Type:_____)
- o © History of Chemotherapy or radiation

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:_____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5		○
2. Nasal Blockage	0	1	2	3	4	5		○
3. Sneezing	0	1	2	3	4	5		○
4. Runny nose	0	1	2	3	4	5		○
5. Cough	0	1	2	3	4	5		○
6. Post-nasal discharge	0	1	2	3	4	5		○
7. Thick nasal discharge	0	1	2	3	4	5		○
8. Ear fullness	0	1	2	3	4	5		○
9. Dizziness	0	1	2	3	4	5		○
10. Ear pain	0	1	2	3	4	5		○
11. Facial pain/pressure	0	1	2	3	4	5		○
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		○
13. Difficulty falling asleep	0	1	2	3	4	5		○
14. Wake up at night	0	1	2	3	4	5		○
15. Lack of a good night's sleep	0	1	2	3	4	5		○
16. Wake up tired	0	1	2	3	4	5		○
17. Fatigue	0	1	2	3	4	5		○
18. Reduced productivity	0	1	2	3	4	5		○
19. Reduced concentration	0	1	2	3	4	5		○
20. Frustrated/restless/irritable	0	1	2	3	4	5		○
21. Sad	0	1	2	3	4	5		○
22. Embarrassed	0	1	2	3	4	5		○

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England.

Patient name: _____

Please answer the following questions if you have any sinus or allergy symptoms.

SINUS SYMPTOM Screening:

Have you been treated for ***acute sinusitis*** (inflammation of the nose and sinuses associated with sudden onset of symptoms of purulent nasal drainage AND nasal obstruction or facial pain/pressure/fullness) 4 or more times in the last year.

☐No ☐Yes

Have you had at least 2 of the following symptoms (discolored nasal drainage, nasal obstruction, or facial pain/pressure/fullness) present for more than 12 weeks ***(chronic sinusitis)***.

☐No ☐Yes

*If you answered **YES to at least 1** of the above questions, please complete the questions below the line.*

TREATMENTS:

1. Have you used ***antibiotics*** to treat the above sinus symptoms?

   ☐No ☐Yes (Provide details below)

Date	Medication	Length of treatment (_____days)	Effectiveness

2. Have you used ***nasal steroids*** such as Flonase (fluticasone), Nasacort (triamcinolone), Rhinocort (budesonide), Nasonex (mometasone) or other nasal steroid to treat the above sinus symptoms?

   ☐No ☐Yes (Provide details below)

Date	Medication	Length of treatment (___weeks)	Effectiveness

3. Have you used ***nasal saline*** irrigation to treat the above sinus symptoms?

   ☐No ☐Yes (_____weeks)

4. ☐ I have ***allergy symptoms*** and have used environmental controls AND allergy medication such as antihistamine, nasal steroid spray, or Singular(montelukast) but my symptoms persist.

   ☐ I have had ***allergy testing*** in the past. Results:_____

   ☐ I have been on ***nasal antihistamine*** (prescription azelastine or olopatadine) and/or ***decongestant*** such as Sudafed (pseudophedrine) or Afrin (oxymetazoline) type spray but my symptoms persisted.

DIAGNOSTICS:

*Information regarding **ANY** previous workup will allow us to provide you with the highest quality of care.*

1. Have you seen an ENT for evaluation of your sinus symptoms?

   ☐No ☐Yes (complete details below)

   If yes please provide details: (name / date / treatment):_____

2. Have you had a nasal endoscopy ("scope") in the past?

   ☐No ☐Yes (complete details below)

   If yes please provide details: (name / date / results):_____

3. Have you had a CT scan of the sinuses?

   ☐No ☐Yes (complete details below)

   If yes please provide details: (name / date / results):_____

   Do you have this imaging report or study with you today? ☐No ☐Yes (please give report to/study to the front desk)