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

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

PRIVIA
MEDICAL GROUP

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

➔ **Signature:** _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: _____

****Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.***

myPRIVIA™
YOUR HEALTH YOUR WAY

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ DOB: _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:** _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication:** _____

- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:** _____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below.**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•**Name:** _____ **Telephone:** _____ **Relationship:** _____
Email:: _____

•**Name:** _____ **Telephone:** _____ **Relationship:** _____
Email:: _____

•**Name:** _____ **Telephone:** _____ **Relationship:** _____
Email:: _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)