Valley Ear, Nose and Throat Specialists, P.A.

PATIENT INFORMATION SHEET
(PLEASE PRINT)

Patient Name ______________________ Male Female

Date of Birth: ______ / ______ / ______ Age: ______ SS#: ______ - ______ - ______

Address: ______________________ City: ______ State: ______ Zip: ______

Home#: ( ) ______ Work#: ( ) ______ Cell#: ( ) ______

If patient is a minor: Parent/Guardian Name: ______ Spouse's Name: ______

Parent/Guardian DOB: ______ Parent/Guardian SS#: ______

Referring Doctor Name: ______ Phone #: ( ) ______

Please indicate the reason for your visit today: ______

How did you hear about Valley Ear, Nose & Throat Specialists? Circle One Email Address: ______

Physician Patient Yellow Pages Website Radio TV Other: ______

Please Circle a Response for Each Organ System

HEAD AND NECK			GASTROINTESTINAL			Skin allergy	Yes	No	HEMATOLOGIC		
Ear Infection	Yes	No	Gastric reflux disease	Yes	No	Skin infections	Yes	No	Easy bruising	Yes	No
Snoring / Apnea	Yes	No	Nausea	Yes	No	NUTRITION/FEEDING			Bleeding problems	Yes	No
Recurrent Tonsillitis	Yes	No	Diarrhea/Constipation	Yes	No	Weight loss/gain	Yes	No	Anemia	Yes	No
History of cleft lip / palate	Yes	No	Regurgitation	Yes	No	Failure to thrive	Yes	No	MUSCULOSKELETAL		
Sinus Infection	Yes	No	G-tube	Yes	No	Food allergies	Yes	No	Bone problems	Yes	No
Sinus allergies	Yes	No	J-tube	Yes	No	Weak suck	Yes	No	Joint problems	Yes	No
Recurrent sore throat	Yes	No	NG-tube	Yes	No	Feeding difficulties	Yes	No	Birth defects	Yes	No
Hearing Problems	Yes	No	Night waking with cough	Yes	No	Limited food variety	Yes	No	Positioning issues	Yes	No
DEVELOPMENT			PULMONARY			Altered diet texture	Yes	No	GENITOURINARY		
Speech delay	Yes	No	Asthma	Yes	No	NEUROLOGIC			Kidney problems	Yes	No
Language delay	Yes	No	Aspiration	Yes	No	Weakness or numbness	Yes	No	Recurrent UTI	Yes	No
Motor Delay	Yes	No	Bronchitis	Yes	No	Seizures	Yes	No	Genital defects	Yes	No
Oral sensory issues	Yes	No	Cough	Yes	No	Headaches	Yes	No	GENERAL		
Downs Syndrome	Yes	No	Noisy breathing	Yes	No	Hydrocephalus shunt	Yes	No	Persistent Fever	Yes	No
HEART			Kidney problems	Yes	No	Neurodegenerative	Yes	No	School absence	Yes	No
Arrhythmia	Yes	No	Trach	Yes	No	Hypotonia	Yes	No	Day care	Yes	No
Murmur	Yes	No	DERMATOLOGIC			Hypertonia	Yes	No	Immunization up to date	Yes	No
Birth defects	Yes	No	Rash	Yes	No	Cerebral Palsy	Yes	No	Allergic to Latex	Yes	No

FAMILY HISTORY			SOCIAL HISTORY			PAST SURGERIES	YEAR
History of Bleeding Tendencies?	Yes	No	Single parent household?	Yes	No		
History of Reaction to Anesthesia?	Yes	No	Is the household bilingual?	Yes	No		
History of Hearing Loss?	Yes	No	Does the patient smoke or is exposed to smoke?	Yes	No		
History of inherited birth defects?	Yes	No	Is there a history of alcohol/drug abuse or was				
History of Allergies/Asthma?	Yes	No	there exposure to patient during pregnancy?	Yes	No		
History of Ear or Tonsil problems?	Yes	No	Is the patient in daycare, preschool or of school age?	Yes	No		

How many ear infections has the patient had in the last 12 months?

How many sinus infections has the patient had in the last 12 months?

How many tonsil infections has the patient had in the last 12 months?

Please include any other pertinent information regarding personal or family history for this patient:

I authorize Valley Ear, Nose and Throat Specialist, P.A. to release any information acquired in the course of my examination or treatment, (medical history, consultation, prescriptions or treatment and copies of all hospital and medical records) to other physicians or groups involved in my health care.

Name of Patient ______ Parent or Guardian ______ Date ______

The above information was reviewed carefully with the patient ______ MD ______ MA

Medication List

Valley Ear, Nose & Throat Specialists, P.A.
2101 S. Cynthia, Plex A
McAllen, TX 78503
956-687-7896

Patient Name: ______________________________ **DOB:** ____________________

Pharmacy Name: ________________________ **Pharmacy Phone Number:** ______________

Please document all current medications below

(Note: please make medical assistant aware of any new medications at each visit)

RX Medication	Date Given	RX Medication	Date Given

Allergic to any medications? Yes_____/ No_____

If yes, please list the medications below in the chart

Medication	Date	Reaction	Medication	Date	Reaction

PATIENT NAME: ______________________________ **DOB:** _______________

REGARDING DIAGNOSTIC PROCEDURES/EAR CLEANINGS

It is not our practice to verify insurance coverage for routine diagnostic audio testing, ear cleanings, or scopes. Your insurance may not cover these procedures as part of the office visit and/or may apply these charges to your deductible.

If you have any questions regarding test or procedures ordered, please do not hesitate to inquire with our staff.

I understand that Valley Ear, Nose & Throat will bill my insurance on my behalf. However, I understand that should my insurance not cover a test or procedure, I will be responsible for the charges incurred.

X ____ __________________

Patient/Responsible party Signature **Date**

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HEALTH INSURANCE CLAIMS

I authorize the release of any medical information necessary to process this claim.

I authorize payment of medical benefits to the physician or supplier for services described in the attached claim form.

X ____ __________________

Patient /Responsible party Signature **Date**

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTCE

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

X ____ __________________

Patient /Responsible party Signature **Date**