

**Patient's Information**

Patient's Legal Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First Initial

DOB: \_\_\_\_\_ Sex: **M F** Marital Status: **S M W D**

Mailing Address: \_\_\_\_\_  
Street or PO Box City State Zip Code

Street Address: \_\_\_\_\_  
If different than above

Cell Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Is it okay to leave a detailed message on both Phone Numbers listed above? **Y N**

**Emergency Contact**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Spouses DOB: \_\_\_\_\_ Spouse SSN: \_\_\_\_\_

Spouses Cell Phone #: \_\_\_\_\_ Spouses Work/Other Phone #: \_\_\_\_\_

Name of PHARMACY: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Responsible Party Information (If Patient is a MINOR this is the LEGAL GUARDIAN Signing Contract)**

Legal Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street or PO Box City State Zip Code

Relationship to Patient: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Consent to Obtain Patient Medication History**

Medication history is important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is oftentimes required to obtain authorizations for further treatment such as CT scans and surgery. **By signing this consent, I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

Signature of Patient, Parent or Guardian: \_\_\_\_\_

**Authorization to Release Protected Health Information**

Cass Street Ear, Nose & Throat Associates, P.C. and its employees may discuss my medical conditions/information with the following individual(s):

\_\_\_\_\_  
\_\_\_\_\_  
Name Relationship Name Relationship

**Medicare Patients**

I request payment of authorized Medicare benefits be made on my behalf to Cass Street Ear, Nose & Throat Associates, P.C. for any services furnished by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This request is effective until revoked by beneficiary in writing.

Signature of Patient or Guardian: \_\_\_\_\_

**Consent For Treatment**

I authorize Cass Street Ear, Nose & Throat Associates, P.C. to render medical treatment to myself or my minor child.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

**Acknowledgement of Offering of Notice of Privacy Practices**

By checking this box, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

**Documentation of Failure to Obtain Signed Acknowledgement**

Patient refuses to acknowledge Notice of Privacy Practice.

**Acknowledgement of Assignment of Benefits and Patient Responsibility**

I understand that it is my responsibility to notify Cass Street Ear, Nose & Throat Associates, P.C. of any changes in my insurance. I understand that not updating my insurance information may result in nonpayment by my insurance carrier due to lack of authorization and/or timely filing limits.

I understand that any balance owed by me may accrue interest at a rate up to the maximum allowable by law. I understand that collection expenses and re-billing charges or late fees may be added to my account if my balance is not paid in full.

**Acknowledgement of Cancellation and No Show Policy**

**I understand the following:**

**No Show for Office Call:** If I am a No Show for my scheduled appointment I will be charged a \$30 No Show Fee.

**Cancellation of Office Call:** If I do not cancel or reschedule an appointment with at least 24 hours' notice I will be charged a Cancellation Fee of \$30.

**Allergy Testing Cancellation or No Show:** If I am a No Show or I do not cancel or reschedule my Allergy Test with at least 7 days' notice I will be charged a \$100 cancellation/no show fee.

**Surgery/Office Procedure Cancellation or No Show:** If I am a No Show or I do not cancel or reschedule my surgery with at least 14 days' notice I will be charged a \$100 cancellation/no show fee.

Cancellation and No Show Fees are not covered by my insurance company and must be paid before I can reschedule my appointment.

**PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient/Parent/Guardian Printed Name

\_\_\_\_\_  
Date

**CASS STREET EAR, NOSE & THROAT ASSOCIATES, P.C.**  
**NEW PATIENT HEALTH HISTORY QUESTIONNAIRE**

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

Current Occupation: \_\_\_\_\_ **What complaint brings you here today:** \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Arthritis/Rheumatoid Problems	YES – NO	If yes, what problem? _____
Asthma/Emphysema/COPD	YES – NO	If yes, what problem? _____
Eye/Vision Problems	YES – NO	If yes, what problem? _____
Hepatitis/Liver Disease	YES – NO	If yes, what type? _____
Heart Disease	YES – NO	If yes, what kind? _____
Anxiety	YES – NO	
Depression	YES – NO	
Diabetes	YES – NO	If yes, what type? _____
High Blood Pressure/Hypertension	YES – NO	
Human Immunodeficiency Virus (HIV)	YES – NO	
High Cholesterol/Hyperlipidemia	YES – NO	
Bleeding Disorder/Hemophilia	YES – NO	If yes, what problem? _____
Kidney Stones	YES – NO	
Neurological Problems	YES – NO	If yes, what problem? _____
Gastrointestinal Problems	YES – NO	If yes, what problem? _____
Psychiatric/Mental Problems	YES – NO	If yes, what problem? _____
Personal History of Cancer	YES - NO	If yes, what kind? _____
History of MRSA	YES – NO	If yes, where on the body? _____
History of Tuberculosis	YES – NO	
Sexually Transmitted Disease	YES –NO	If yes, what kind? _____

**PAST SURGICAL HISTORY:** \_\_\_\_\_

**RADIOLOGY:** Have you had an x-ray, MRI or CAT Scan of your head or neck in the past year? YES – NO If yes, what for? \_\_\_\_\_

**AUDIOLOGY:** Have you had a hearing test in the past year? YES – NO If, yes, where did you have it and when? \_\_\_\_\_

**EAR/NOSE/THROAT PAST MEDICAL HISTORY**

Outer Ear Infections # of episodes in last year _____	Right – Left – Both – None	Hoarseness	YES – NO
Inner Ear Infections # of episodes in last year _____	Right – Left – Both - None	Neck Mass	YES – NO
Environmental Allergies	YES – NO	Nasal Polyps	YES - NO
Deviated Septum	YES - NO	Sinusitis	YES - NO
Epistaxis/Bloody Noses	YES – NO	Sleep Apnea/OSA	YES – NO If yes, are you on CPAP? _____ How long have you been on CPAP? _____
History of Noise Exposure	YES – NO	Thyroid Nodules/Masses	YES - NO
GERD/Reflux	YES – NO	Tinnitus/Ringing in Ears	Right – Left – Both - None
Headache	YES – NO	Tonsillitis/Strep Throat	Yes – No # of episodes per year _____
Hearing Loss	Right – Left – Both – None	Vertigo	Right – Left – Both - None
		Vocal Cord Paralysis	YES - NO

**PLEASE FILL OUT THE FOLLOWING IF PATIENT IS A MINOR:**

Are patient's immunizations up to date?	YES – NO	Are there brothers and /or sisters in the home?	YES – NO
Are there smokers in the home?	YES – NO	Is the patient exposed to tobacco smoke outside the home?	YES – NO
Does patient attend daycare or school?	YES – NO	Is the patient a product of a normal pregnancy and delivery?	YES – NO
Are there pets in the home?	YES – NO	If no, what kind? _____	

**PLEASE LIST OR ATTACH ALL MEDICATIONS YOU CURRENTLY TAKE, INCLUDING OVER THE COUNTER MEDICATIONS:**

Name of Medication	Dosage	Frequency	Reason for taking

**ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO**

If yes, please list medication and reaction: \_\_\_\_\_

**Do you have any food allergies? YES NO**

If yes, please list food and reaction: \_\_\_\_\_

**Have you ever had a severe allergy reaction that required emergency treatment? If yes, describe** \_\_\_\_\_

**SOCIAL HISTORY:**

Do you currently use tobacco? YES – NO Which type? cigarettes cigars chew vapor

How many packs per day? \_\_\_\_\_ Total years you have used tobacco? \_\_\_\_\_

Are you a previous tobacco user? Yes - NO If yes, when did you stop? \_\_\_\_\_

Do you have a history of Past or Current drug use including medical marijuana? YES – NO \_\_\_\_\_

Do you consume alcohol? Yes – NO How many alcohol drinks per day \_\_\_\_\_ per week \_\_\_\_\_

(men) how many times in the last year have you consumed more than 5 drinks at a time? \_\_\_\_\_

(women) how many times in the last year have you consumed more than 4 drinks at a time? \_\_\_\_\_

**PATIENTS 64 AND OLDER:**

Have you had a pneumonia vaccination? Yes No

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No

Do you have a living will? Yes No

Which statement best reflects your wishes on advanced care recommendations:

Do Not Intubate                       Do Not Resuscitate                       Full Cardiopulmonary Resuscitation

**FAMILY HISTORY: (Grandparents, Parents, Siblings and Children only) DO ANY OF YOUR RELATIVES HAVE (HAD):**

Heart Disease YES – NO If YES, relation \_\_\_\_\_ Stroke YES – NO If YES, relation \_\_\_\_\_

Early Onset Hearing Loss YES – NO If YES, relation \_\_\_\_\_ Asthma YES – NO If YES, relation \_\_\_\_\_

High Blood Pressure YES – NO If YES, relation \_\_\_\_\_ Diabetes YES – NO If YES, relation \_\_\_\_\_

Environmental allergies YES – NO If YES, relation \_\_\_\_\_ Cancer YES – NO If YES, what kind/relation \_\_\_\_\_

**ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:**

Onset of new headaches YES - NO                      Hearing Loss YES - NO                      Cough YES – NO

Chest pain YES - NO                      Shortness of breath YES - NO                      Joint or muscular pain YES - NO

Rash or skin lesion YES - NO                      Heartburn or indigestion YES - NO                      Ear Infection YES - NO

Sleeping difficulties YES - NO                      Weight Loss YES - NO                      Ear Pain YES - NO

Cold intolerance YES - NO                      Weight Gain YES - NO                      Vertigo YES - NO

Heat intolerance YES - NO                      Fatigue YES - NO                      Tinnitus YES - NO

Recent Fever YES – NO If yes, Temp. \_\_\_\_\_                      Hoarseness YES - NO                      Nasal Obstruction YES - NO

**Do you take Aspirin, Blood Thinners or Ibuprofen on a daily basis? YES – NO                      Latex allergies/reactions YES – NO**

**Have you received the COVID-19 Vaccination? YES – NO                      If Yes did you receive both the first and second doses? YES – NO**