We are looking forward to being a part of your healthcare team. Please complete the enclosed packet referencing your medical history. Please bring your insurance cards, a list of all current medications, and a copy of all recent tests relating to the problem which we are seeing you for, (CT, MRI, Ultrasound discs and reports if available). *For identification purposes, your picture is taken for your chart. This is a requirement to be seen at our office and no exceptions can be made*.

Please *bring your* **completed paperwork** and pharmacy information to your appointment and **arrive 20 minutes** early for registration. If your insurance requires an **insurance referral** *this **MUST** come from your primary care physician and you cannot be seen without it*. This information will be on your insurance card. Your office visit co-payment will be collected at check in. If we have to bill you for the co-payment there will be a $5.00 processing fee.

Our office is located at 9 Brookwood Avenue, Carlisle PA 17015

Thank you for taking the time to prepare for your visit. Your appointment has been scheduled for Month___________, Day_____________and time_____________.

If you have any questions or if you cannot keep your appointment, please call us ***within 24 hours prior*** to your appointment time at (717) 243-0616 to avoid a fee.

NOTE- Carlisle ENT retains the right to charge $100.00 for appointments that are not cancelled within 24 hours or does not show up for the appointment. Carlisle ENT has the right to choose not to reschedule the appointment. If the appointment is rescheduled the $100.00 fee will be collected prior to rescheduling and applied towards that rescheduled visit. If the appointment is not rescheduled the $100.00 fee will remain patient responsibility.

Patient Acknowledgement_______________________

Unfortunately, When a patient does not show up for a scheduled appointment that is taking an appointment time away that could have been used for another patient waiting to be seen.

You may fax completed paperwork to 717-245-2351 but, please bring hard copy incase not received. Thank you!

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW:

DEMOGRAPHIC INFORMATION:

Name: ___________________________________ Today's Date: ___________________________

Date of Birth: ____________________________ Sex: Male or Female

Address: ____

City: _________________________ State: ___________________ Zip code: __________

Home#: _______________________ Work#: __________________ Cell#: ______________

Email Address: ____

Emergency Contact: _______________________ **Phone#**_______________________________

Relation: ____

Primary Pharmacy: ____

Mail Order Pharmacy: ____

Race: (circle one)

American Indian/Alaskan Native

Asian

African American/Black

Native Hawaiian / Other Pacific Islander

Caucasian/White

Refused

Ethnicity (circle one)

Not Hispanic / Latino

Non-Hispanic African

Refused

Primary Language: ____

PRIMARY INSURANCE INFORMATION:

Insurance Name: _________________________________ ID#______________________

Subscriber's Name: ________________________________ Subscriber DOB___________

SECONDARY INSURANCE INFORMATION:

Insurance Name: ____________________________ ID#_________________________

Subscriber's Name: __________________________ Subscriber DOB_______________

Patient Name:___________________________ **Date of Birth:**_______________

NEW PATIENT MEDICAL HISTORY FORM:

Preferred Name: ____________________________________ Date: ___________________

What Pharmacy do you use? ____

Were you referred to our office? Yes or No

If yes, by whom? ____

Review of Medical Symptoms:

At this time do you have any following complaints?

Please answer Yes or No

Constitutional: Fatigue__________ Weight Change __________ Fever ___________

Eyes: (Y/N) _____

Cardiovascular: (Y/N) ____

Respiratory: (Y/N) ____

Gastrointestinal: (Y/N) ____

Genitourinary: (Y/N) ____

Musculoskeletal (Y/N) ____

Heme/Lymphatic (Y/N) ____

Ear/Nose/Throat (Y/N) ____

Skin: (Y/N) ____

Neurologic (Y/N) ____

Psychiatric (Y/N) ____

Endocrine (Y/N) ____

Allergies (Y/N) ____

Medical Allergies:

Do you have a Latex Allergy? (Yes or No) _________________

Please list all known allergies to medications and your reaction. If none, state N/A:

____

____

Patient Name: ______________________________ **Date of Birth**: _______________________

Have you ever had any complications with Anesthesia? (Yes or No) ________

(If yes, what?)____

Do you have difficulty stopping bleeding or do you have a bleeding disorder (Y/N) _________

Family Medical History:

Does any member of your immediate family (Parents/Siblings/Children) have or have ever been treated for the following: yes or no (if Yes) Whom?

Bleeding Disorder____

Complication with Anesthesia____

High Blood Pressure____

Asthma/Emphysema____

Heart Disease____

Cancer :(Type, Date, Treatment)____

Other: ____

Social History: Your Age: ____________

Marital Status: single married divorced widowed Number of Children: _______

Who lives at home with you? ____

Your Employer: _______________________ (retired) previous Employer: _________________________

Occupation-Position held:

____

Do you or have you ever used: Cigarettes _______ Cigars _______ Tobacco_________

Amount per day: ____________ Years: _______________ Years since you quit: ______________

Do you drink Alcohol? _______ Drinks per day: _____________ Type: ___________________

Do you or have you ever abused drugs? Y/N Type: ___________________

Patient Name________________________ **Date of Birth:** ______________________

Medical History:

Have you ever been hospitalized? (Reason?)

____

____

Please list any current or past medical conditions you have been diagnosed with:

____

____

Have you ever been diagnosed with cancer? (If so what type)

____

____

Have you ever been diagnosed with HIV / Hepatitis /Etc. (Y/N) if Yes, what type?

____

Past Surgical History:

Have you ever had surgery? (What type?)

____

____

____

Have you ever had any procedures or surgeries for your heart?

____

____

Patient Name: _____________________________ Date of Birth: ____________________________

Have you ever had any complications with surgery? (Y/N) _____ If yes, what

____

Medications:

Please list all medication that you currently take including vitamins and non-prescription of alternative medications, the dosage and frequency. If none, please state N/A:

____

____

____

____

____

____

____

____