RICHARD A. WANDZEL, D.O., P.C.
EAR, NOSE & THROAT
FACIAL PLASTICS – COSMETIC SURGERY

222 W. Highland Rd.
Highland, MI 48357
(248) 889-7600
Fax (248) 889-5876

820 Byron Rd., Suite 500
Howell, MI 48843
(517) 548-5900
Fax (517) 548-5982

PATIENT INFORMATION:

***Name**: _____ ***Male / Female**

***Date of Birth**: _____ **Age**: _____ ***Preferred Language**: _____

***Race**: _____ *Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino □ Other

Marital Status: Single/Married/Widowed/Divorced (Circle One) Social Security Number: _____

Mailing Address: _____
Street City Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Method of Contact: (Circle One) Home Phone/Cell Phone/Email (Patient Portal)/Other: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

***Referring Doctor or Primary Care Physician**: _____ Phone: _____
(Circle One)

INSURANCE INFORMATION:

Primary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient Insured (Circle One) Self/Spouse/Child/Other (Explain) _____

Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient Insured (Circle One) Self/Spouse/Child/Other (Explain) _____

WORKMAN's COMPENSATION: YES NO AUTO ACCIDENT: YES NO

I authorize the release of information needed to process claims to the insurance company and assign all benefits to Richard A. Wandzel, D.O.. I understand and agree that I am responsible for the balance on my account. I certify that this information is true and correct to the best of my knowledge. I will notify the office of Richard A. Wandzel, D.O. of any changes in my health status or insurance information.

X_____ _____
PATIENT SIGNATURE or RESPONSIBLE PARTY DATE

RICHARD A. WANDZEL, D.O., P.C.

*Name: _____

*Height _____ *Weight _____

Occupation: _____

Employer: _____

***Family History**

Has anyone in your family had any of the following?

Heart Disease	YES	NO
Stroke	YES	NO
Cancer	YES	NO
Bleeding Disorder	YES	NO
Diabetes	YES	NO
Hearing Loss	YES	NO
Hypertension	YES	NO

***Social History**

Do you use tobacco? YES NO

If YES, how many packs/Day and # yrs.: _____

Year Quit: _____

Do you use alcohol? YES NO

If YES, what type and amt. per week: _____

Do you consume caffeine? YES NO

If YES, how many cups per day: _____

Do you/have you had a problem with chemical dependency or recreational drug use? YES NO

Are you pregnant? YES NO

Any History of Cancer? YES NO

If YES, please describe: _____

_____

***REVIEW OF SYSTEMS:**

GENERAL	EYES	EAR, NOSE, THROAT	CARDIAC	RESPIRATORY
☐ **None**	**None**	☐ **None**	☐ **None**	☐ **None**
☐ Weakness	☐ Blurred Vision	☐ Hearing Loss	☐ Irregular Heartbeat	☐ Cough
☐ Fatigue	☐ Itchy/Irritated Eyes	☐ Ear Infections	☐ Poor Circulation	☐ Asthma
☐ Fever/Chills	☐ Eye Pain	☐ Nose Bleeds	☐ High Blood Pressure	☐ Shortness of Breath
☐ Headaches	☐ Tearing	☐ Sore Throat	☐ Cardiac Disease	☐ Difficulty Breathing
☐ Dizziness	☐ Cataracts	☐ Snoring/Sleep Apnea	☐ History of Heart Attacks	☐ Wheezing
☐ Night Sweats	☐ Glaucoma	☐ Vertigo	☐ High Cholesterol	☐ Pneumonia
☐ Other:	☐ Other:	☐ Tinnitus	☐ Other:	☐ Pulmonary Disease
		☐ Other:		☐ Other:

GASTROINTESTINAL	GENITOURINARY	MUSCULOSKELETAL	SKIN	NEUROLOGICAL
☐ **None**	☐ **None**	☐ **None**	☐ **None**	☐ **None**
☐ Reflux/GERD	☐ Difficulty w/Urination	☐ Joint Swelling/Pain	☐ Skin Color Change	☐ Tremors
☐ Heart Burn	☐ Kidney Disease	☐ Muscle Aches	☐ Skin Rashes	☐ Epilepsy/Seizures
☐ Nausea/Vomiting	☐ Pain/Burning	☐ Back Pain	☐ Itchy Skin	☐ Memory Loss
☐ Poor Appetite	☐ Blood in Urine	☐ Arthritis	☐ Skin Sores	☐ Stroke/TIA
☐ Abdominal Pain	☐ Infections	☐ Other:	☐ Head/Facial Lesions	☐ Other
☐ Other:	☐ Other:		☐ Skin Cancer	
			☐ Other:	

PSYCHIATRIC	ENDOCRINE	HEMATOLOGY	IMMUNOLOGY	ORAL
☐ **None**	☐ **None**	☐ **None**	☐ **None**	☐ **None**
☐ Depression	☐ Diabetes	☐ Anemia	☐ Sneezing	☐ Bleeding Gums
☐ Anxiety	☐ Thyroid Disease	☐ Clotting Disorder	☐ Runny Nose	☐ Dental Problems
☐ Insomnia	☐ Weight Loss	☐ Bruises Easily	☐ Skin Sensitivity	☐ Ulcers/Blisters/Sores
☐ Other:	☐ Weight Gain	☐ Aspirin Use	☐ Allergies	☐ Loss of Taste
	☐ Hyperglycemia	☐ Blood Thinner Use	☐ AIDS/HIV	☐ Bad Breath
	☐ Other:	☐ Other:	☐ Autoimmune Disease	☐ Other:
			☐ Other:	

Reason for Visit Today: _____

RICHARD A. WANDZEL, D.O., P.C.

Name: _____

*PREVIOUS HOSPITALIZATIONS, SURGERIES and MEDICAL ILLNESS		
DATE (approx.. year)	**REASON**	**PLACE (hospital)**

☐ **NO SIGNIFICANT HOSPITALIZATIONS, SURGERIES and MEDICAL ILLNESS NOTED** ☐ **REFER TO LIST**

Have you had any serious problems with anesthesia? If so, what? _____ YES NO
Is there any family history of problems with anesthesia? _____ YES NO
Are there any personal/religious reasons you would refuse blood transfusions? _____ YES NO

*LIST OF CURRENT MEDICATIONS		
NAME OF MEDICATION	**DOSAGE**	**ROUTE (mouth, injection, inhaler)**

☐ **CURRENTLY DOES NOT TAKE ANY MEDICATIONS** ☐ **REFER TO LIST**

Pharmacy Name: _____ Location/Phone number: _____

***ALLERGIES** ☐ **NO KNOWN DRUG ALLERGIES**

ARE YOU ALLERGIC TO:

			If YES, please describe reaction:
LATEX	YES	NO	_____
FOODS	YES	NO	_____
IODINE (on skin)	YES	NO	_____
ADHESIVE TAPE	YES	NO	_____
OTHER ALLERGIES _____			_____

*LIST OF MEDICATION ALLERGIES:	
MEDICAL ALLERGY	**REACTION**

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(Including)

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HIPPA PRIVACY ACT

Your doctors and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

As our patient, you possess the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I authorize you to use or disclose my health information in the manner described in the HIPPA form that was offered to me for my review. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This authorization will expire seven years after the date signed.

You may opt out from mailings and phone calls by marking the box below.

( ) Please do not contact me for the above reasons.

_____
Signature of Patient (or parent if a minor)

_____ _____
Printed Patient Name Date