MODERN NOSE CLINIC
ALLERGY, SINUS & SNORING

Douglas J. Skarada, MD, FAAOA
Nahmjee Lee, DMD

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: (First, MI, Last)			Sex: [ ] M [ ] F
Birth Date:	Age:	SS#:	Email:
Race:	Ethnicity:		Language:
Mailing Address:			Work Ph: ( )
City:	State:	Zip Code:	Home Ph: ( )
			Cell Ph: ( )
Patient's Employer/Company:			Occupation:
For Minor Patients:	Father:	Mother:	Guardian:

GENERAL INFORMATION

How were you referred to this clinic? PCP [ ] Specialist [ ] Newspaper [ ] Website [ ] Yellow Pages [ ] Other _____
Who is your Primary Care Physician? Office Ph: ( )
Are you a former patient? [ ] No. [ ] Yes. Are any family members former patients? [ ] No. [ ] Yes.

CONSENT TO SHARE HEALTH INFORMATION

If you would like to give us permission to discuss your health information with someone, OTHER than your Physician(s), please ask for our Consent to Share Health Information form.

EMERGENCY CONTACT (OUTSIDE OF YOUR HOME)

Name:	Relationship:
Work Ph: ( )	Home Ph: ( )

FINANCIAL RESPONSIBILITY

Responsible Party's Name:	DOB:	Relationship to patient:
Responsible Party's Address: (if different from above)		
Employer:		Office Ph: ( )
Spouse's or Parent's Name: (First, MI, Last)		Occupation:
Spouse's or Parent's Employer:		Office Ph: ( )

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INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Policy Holder:	DOB:	Policy Holder:	DOB:
Group Number:		Group Number:	
ID Number:		ID Number:	
Ins. Co. Address:		Ins. Co. Address:	

_____ _____

Signature of Patient or Legal Guardian Date

PAYMENT AUTHORIZATION

I, the undersigned, authorize payment of medical benefits to the physician for services rendered. I authorize the release of any medical information necessary of said services including cosmetic procedures performed in conjunction with medically necessary procedures. I understand that I am responsible for any and all charges for services rendered that are not covered or paid for by my insurance company.

_____ _____

Patient/Responsible Party Last 4 Digits of SSN DOB Date

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Name _____ Age _____ Birthdate _____ ☐ M ☐ F

Weight _____ lbs. Height _____ ft. _____ in. Are you pregnant? ☐ Yes How many weeks? _____

Occupation _____ Pharmacy _____

Physician Referring for Consultation _____ Primary Care Physician _____

Chief complaint or ENT concerns today _____

If you have been seen/treated by an ENT previously, please list their name and contact information below:

_____

Have you had a recent CT/MRI/Xray or Hearing Test pertaining to today's visit? Where and when?:

CT/MRI/Xray: ☐ Yes _____ Hearing Test: ☐ Yes _____

Allergies to Medication	Reaction	Allergies to Medication	Reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Other Allergies and Reactions

☐ Adhesive Tape _____ ☐ Iodine _____

☐ Skin Cleansing Solution _____ ☐ Latex _____

Seasonal/Environmental Allergies ☐ Yes ☐ No ☐ Other _____

If yes, please circle any that apply to your seasonal/environmental allergies:
☐ Grass ☐ Weeds ☐ Trees ☐ Dust ☐ Mold ☐ Cats ☐ Dogs

List current medications with direction and dose:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Aspirin ☐ dosage _____ Blood Thinner ☐ dosage _____ Anti-Inflammatory drugs ☐ dosage _____

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List any medical problems you are currently being treated for:

1. _____ 3. _____
2. _____ 4. _____

Previous ear, nose throat or neck surgeries and date performed:

1. _____ 3. _____
2. _____ 4. _____

All other previous surgeries and date performed:

1. _____ 3. _____
2. _____ 4. _____

Exercise: Frequency _____ Type _____

Tobacco Use: ☐ Never

☐ Current Type of Tobacco _____ Years Used _____ Amount per Day _____ Ever tried to Quit? _____
☐ Former Type of Tobacco _____ Years Used _____ Amount per Day _____ Age Stopped? _____
☐ E-Cigarette Use Years Used _____ Amount per Day _____ Ever Tried to Quit? _____

Do you consume caffeine daily? ☐ Yes ☐ No Type _____ Frequency _____ Amount _____
Do you consume alcohol? ☐ Yes ☐ No Type _____ Frequency _____ Amount _____

Patient Medical History

Have you or any family member ever had an unusual reaction to anesthesia? ☐ Yes ☐ No
Who? _____ Reaction _____
Do you have a family history of malignant hyperthermia? Who? _____ ☐ Yes ☐ No
Do you have a family history of a bleeding disorder? Who? _____ ☐ Yes ☐ No
Do you have unusual bruising or bleeding from cuts, surgery or tooth extraction? ☐ Yes ☐ No
Do your personal convictions prohibit blood transfusions? ☐ Yes ☐ No

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Have you ever had the following disorders? Include year of onset:

Disease or Disorder	Y	Disease or Disorder	Y	Disease or Disorder	Y
Chest Pain		Headaches		Angioedema/Hives	
Heart Disease		Migraines		HIV	
Heart Attacks		Multiple Sclerosis		Lupus	
High Blood Pressure		Parkinson's Disease			
High Cholesterol		Diabetes		Bladder Disorder	
Irregular Heartbeat		Thyroid Disorder		Enlarged Prostate	
Pacemaker				Kidney Failure	
Stroke		Anemia			
		Bleeding Disorder		Arthritis	
Asthma		Form Large Scars/Keloids		Fibromyalgia	
COPD		Cancer of:		Neck Disorder	
Pneumonia				Back Disorder	
Sleep Apnea		Hearing Impairment			
Use CPAP		Tinnitus/Ringing of Ears		Anxiety	
Tuberculosis		Vertigo		Bipolar Disorder	
Use Oxygen		Nose Bleeds		Depression	
		Snoring		Mental Disease	
Attention Deficit Disorder		TMJ		Psychiatric Care	
Autism		Visual Impairment			
Bell's Palsy				Born Pre-Mature	
Cerebral Palsy		Hepatitis/Liver Disorder		How many weeks?	
Seizures		Reflux/Heartburn		Shortness of Breath	
Dementia		Stomach Ulcers		Swelling of legs/ankles	

Please tell us about some of your family history: ☐ I am adopted ☐ I am a foster child

Check any that apply with the specified family member

Mother ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Father ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Sister ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Brother ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Daughter ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Son ☐ Blood Disorder ☐ High Blood Pressure ☐ Allergies ☐ Sleep Apnea ☐ Cancer, type _____
☐ Heart Disease ☐ Hearing Impairment

Patient Signature _____ Date _____