MEDICAL QUESTIONNAIRE

Alamogordo Ear, Nose and Throat Sinus Center ▲ Dermatology

Patient Name:_____

Date of Birth (MM/DD/YYYY):_____

Reason for visit: _____

_____

Past Medical History and Surgical History: (Check all that apply. If NONE, please check NONE)

□Arthritis	□GERD	□Lupus/RA	□Liver transplant
□Asthma	□Hearing loss	□Lymphoma	□Ovarian removal
□Bleeding Disorder	□Hepatitis A, B, or C	□Organ Transplant	□Pancreas removal
□Cancer:_____	□High blood pressure	□Breast mastectomy	□Prostate removal
□Coronary Artery Bypass	□HIV/AIDS	□Colon removal	□Rectum Resection
□Depression	□High cholesterol	□Heart valve replacement	□Spleen removal
□Diabetes	□Hyperthyroidism	□Joint replacement	□Testicle removal
□End Stage Renal Disease	□Hypothyroidism	□Kidney transplant	□Uterus removal

Do you have a history of Skin Cancer or Skin Disorders? (Examples: acne, actinic keratosis, basal cell carcinoma, malignant melanoma, psoriasis, squamous cell carcinoma) Yes___ No____ If yes, please indicate condition or disorder:

_____

Family History of Skin Cancer including Melanoma? Yes___ No____
If yes, whom:_____

Medications: (Enter all current medications including non-prescription and birth control; if none mark N/A)

_____

Allergies: (Please enter all allergies including allergy to medications; if none mark N/A)

_____

Social History:
Do you smoke? Yes___No____ if yes, how much?_____ Do you drink alcohol? Yes___No____ If yes, how much?_____

Review of Systems: (Check all that apply)

□ Fever or Chills	□ Problems with healing	□ Persistent infections
□ Night sweats	□ Problems with scarring (hypertrophic or keloid)	□ Immunosuppressed
□ Unintentional weight loss	□ Skin disease	□ NONE
□ Joint aches	□ Problems with bleeding	

Alerts: (Check all that apply. If NONE, please check NONE)

□ Allergy to Adhesive	□ MRSA
□ Allergy to Lidocaine	□ Pacemaker
□ Allergy to Topical Antibiotics	□ Require antibiotics prior to a surgical procedure
□ Artificial Heart Valve	□ Rapid heart beat with Epinephrine
□ Artificial Joint Replacement	□ Pregnant
□ Blood Thinners	□ Currently trying to get pregnant
□ Defibrillator	□ Breastfeeding
	□ NONE

Preferred Pharmacy Name: _____ **Telephone (if known):** _____
Address (or cross streets): _____ **City:** _____

Patient/Guardian Signature:_____ **Date:**_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name (as it appears on Driver's License or Photo ID): **First Middle Last**	**Patient Date of Birth (MM/DD/YYYY):** **Social Security Number:**
Mailing Address (Street, City, State, ZIP):	**Patient Gender (circle): Male I Female** **Marital Status:**
Email Address:	**Occupation:**
Home Phone Number:	**Employer:**
Cell Phone Number:	**Employer Phone Number:**
Referred to Clinic By (Please Circle) **Dr._____ I Family/Friend I Insurance Company I Web Search I Print Ad I Other:_____**	
Primary Care Physician (PCP) Name:	**PCP Phone Number (if known):**

RESPONSIBLE PARTY INFORMATION (Spouse / Parent / Legal Guardian)

Guarantor on Account (e.g., responsible parent if patient is a minor):	**Guarantor Phone Number:**	**Guarantor Relationship to Patient:**
Guarantor Date of Birth (MM/DD/YYYY):	**Guarantor Mailing Address (Street, City, State, ZIP):**	

INSURANCE INFORMATION

Primary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**
Specialist Copay Amount: $_____		
Secondary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**

EMERGENCY CONTACT (Please list anyone you authorize to receive protected health information)

Name:	Relationship to Patient:	Phone Number:

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Alamogordo ENT & Dermatology. I understand that I am financially responsible for any balance. Also, I authorize Alamogordo ENT & Dermatology to release medical information required to process claims.
Notice of Privacy Practices: I have read or been offered a copy of Alamogordo ENT & Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.
Consent for Communication: I understand Alamogordo ENT & Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.
Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Alamogordo ENT & Dermatology and its related companies.
Legal: This form applies to Alamogordo ENT & Dermatology and its related companies.

SIGNATURE

Patient / Guardian Signature:	**Date:**