PERSONAL HISTORY

Name: _____

Do you take any medications? Yes_____ No _____ List all prescriptions & over the counter medications and the strength/dosage_____

_____

_____

What medications have you taken to help with your current ENT condition?_____

Are You Allergic to any Medications? Yes___ No___. Please list the drug and your reaction.

_____

Circle if You have any below. **Indicate which Family members have any below.**

Arthritis	Immune disorders		Arthritis	Immune disorders
Asthma	Lung diseases_____		Asthma	Lung diseases_____
Blood / Bleeding Disorder	Mental Illness_____		Blood/Bleeding Disorder	Mental Illness_____
Cancer_____type	Migraines / Headaches		Cancer_____type	Migraines / Headaches
Other Allergies_____	Sleep Apnea		Other Allergies_____	Sleep Apnea
Diabetes I or II	Stomach condition_____		Diabetes I or II	Stomach condition_____
Heart _____	Strokes / TIA		Heart_____	Strokes / TIA
Hepatitis _____type	Thyroid _____		Hepatitis_____type	Thyroid_____
High Blood Pressure	Tinnitus / Hearing Loss		High Blood Pressure	Tinnitus / Hearing Loss
High Cholesterol	Sinus _____		High Cholesterol	Sinus_____
HIV/AIDS	Other_____		HIV/AIDS	Other_____

List any surgeries other conditions you have been diagnosed with including Ear, Nose or Throat.

_____

_____

Patient's height_____. Patient's weight_____lbs. Last Blood Pressure reading, if known_____/_____.

Do you exercise? Circle one: Never Rarely Occasionally 1-3 x p/ week Daily

Do you drink alcohol? Circle one: Never Rarely Occasionally 1-3 x p/ week Daily

Do you smoke? Y / N / Never If Yes, how much per day?_____. If No, when did you quit? _____.

Circle if you drink coffee, tea, soda or other caffeinated drinks? How much daily_____?

If female, are you pregnant_____? Do you wear a hearing aid? _____?

Are you employed_____? What is or was your Occupation_____?

SIGNATURE_____ **DATE**_____

Updated 12-15-16

Welcome To Our Office

How did you hear about our office_____?

Primary Care Physician: _____**Were you referred by them? Y ___ N __**

Reason for your visit today _____**Duration**_____

Patient's Name: _____

Patient's Address:_____

City_____ **State**_____ **Zip Code**_____

Date of Birth _____ **Age**_____ **Gender**: M_____F_____

Marital Status _____**Single** _____**Married** _____**Divorced** _____**Widowed**

Ethnicity: Hispanic/Non-Hispanic Race: Caucasian/Black/Other_____
Language:_____ **Please circle**

Home Phone# _____

Work Phone# _____

Cell Phone#_____

Emergency Contact: Name _____**Relation**_____ **Phone:**_____

Pharmacy Name / Phone # _____

Primary Insurance: _____ **Secondary Insurance** _____

Policyholder's Name: _____

Policyholder's Date of Birth_____

Parent's Names (if patient is a minor) _____

Patient's Relationship to Policyholder: **SELF SPOUSE CHILD OTHER**

SIGNATURE:
_____**Date**_____

JOSHUA D POLLACK, MD

Financial Affidavit: The guarantor/patient hereby authorizes the release of any medical information necessary to process claims for themselves or their dependents and assigns payment directly to the physician for medical services rendered to same. It is acknowledged that the guarantor/patient is responsible for all charges for all services rendered. Even though the insurance company will be billed on the patient's behalf, it is clearly understood that any balances NOT paid by the insurance company within a timely manner, will become the guarantor's/patient's responsibility.

X_____ _____

Signature **Date**

Release of Information: To give us permission to release information regarding your care or treatment, provide names and phone numbers. **We will not release information to anyone except you or your physician, unless you list them below.**

_____ _____ _____

Name Phone Relationship

_____ _____ _____

Name Phone Relationship

Patient Portal: Our office is in the process of providing access of certain information to patients through our patient portal. To set up this access, please complete the following and sign. You will receive an email with directions as soon as it is available.

Patient's name:_____ Email Address:_____

Social Security #:_____ Signature:_____

Notifications from us: Please check off any acceptable methods for us to contact you or to leave you a message.

Mail_____ Home Phone_____ Cell Phone_____ E-mail_____

Email Address: _____if checked above.

(please print)

HIPAA Privacy Act:

I acknowledge that I have seen the Notice of Privacy Practices. I understand I may ask for a copy at any time.

X_____

Signature

_____

Today's Date

Joshua D. Pollack, M.D.

Patient's Name: _____ Date of Birth _____

Consent for In-Office Endoscopy / Microscopy Procedure

Procedures are routinely performed to treat and/or diagnose conditions of the ears, nose and throat. These procedures carry almost no risk and will provide the doctor with a comprehensive view of the areas involved. However, these procedures, Endoscopies and Microscopies, may be considered surgical procedures by your insurance company.

Diagnostic procedures allow the physician to examine the areas in the ears, nose and throat that cannot be visualized during a routine exam. Other procedures can treat a specific condition you are or may be experiencing.

Prior to the procedure, the physician may spray a decongestant and topical anesthetic into each nostril, or in your throat. This will help with any slight discomfort you may experience. Once the anesthetic takes effect, the procedure is performed.

Your insurance company may not pay these "surgical procedures" at the same rate as your office visits or under your office visit copay, if applicable. Please check with your insurance company if you are unsure of your benefits. We do not have this information for you. When you receive your explanation of benefits, please remember that these procedures are sometimes itemized as surgery by the insurance company, even though they were performed in the office.

By signing this form, you are consenting to these procedures being performed as medically necessary. This consent will remain in effect for future procedures unless otherwise noted.

Please sign below acknowledging your understanding and acceptance of these procedures.

_____	_____	_____
Date	**Patient Signature**	**Witness**