ASSOCIATED EAR, NOSE & THROAT SPECIALISTS, LLC

Todd A. Zachs, M.D.
Sarah Sanford, APRN
Hannah Vollinger, Au.D., CCC-A

Name: _____ Date of Birth: _____
Last *First*
If patient is a minor, parent's name: _____ *Date of Birth:* _____

Address: _____ Apt: _____

Town: _____ State: _____ Zip Code: _____ Male ☐ Female ☐

Phone: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Email Address: _____ Student: Full Time / Part Time

Primary Care Physician: _____ Town: _____

Referring Physician: _____ Town: _____

Emergency Contact: _____ Phone Number: _____
Last *First*

Relationship to Patient: _____

Primary Insurance: _____ ID: _____

Primary Cardholder: _____ Birthdate: _____

Secondary Insurance: _____ ID: _____

Primary Cardholder: _____ Birthdate: _____

Marital Status: Single / Married / Divorced / Widowed / Other / DECLINED
Other: _____

Employment Status: Employed / Unemployed / Retired / Student (full or part time) / DECLINED
Other: _____

Language: English / Spanish / Russian / French / Italian / Polish / DECLINED
Other: _____

Race: White / Black / Hispanic / Asian / African-American / DECLINED
Other: _____

Ethnicity: Caucasian / African-American / Italian / Spanish / Russian / DECLINED
Other: _____

Pharmacy: _____ Address: _____

- IF YOUR INSURANCE REQUIRES REFERRALS, IT IS IMPERATIVE THAT YOU HAVE A WRITTEN OR ELECTRONIC REFERRAL IN PLACE WITH YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT (DEPENDING ON WHICH TYPE IS REQUIRED BY MY INDIVIDUAL INSURANCE PLAN).
- I UNDERSTAND THAT IF I DO NOT HAVE A VALID REFERRAL FROM MY PRIMARY DOCTOR, THAT MY INSURANCE COMPANY COULD REFUSE TO PAY FOR MY VISIT. IF MY INSURANCE REQUIRES REFERRALS AND I FAIL TO OBTAIN A VALID REFERRAL, I AGREE TO ASSUME FULL RESPONSIBILITY FOR PAYMENT OF SERVICES.
- I UNDERSTAND THAT INSURANCE CO-PAYS ARE DUE AT THE TIME OF MY VISIT.
- I UNDERSTAND THAT THE DOCTORS UTILIZE SCRIBES IN THE EXAM ROOMS AND I GIVE PERMISSION FOR A SCRIBE TO BE PRESENT DURING MY EXAMINATION.
- I UNDERSTAND THAT 24-HOUR NOTICE IS REQUIRED TO CANCEL MY APPOINTMENT(S) AND THAT I WILL BE CHARGED FOR A "NO SHOW VISIT' IF I FAIL TO CALL WITHIN 24 HOURS OF MY SCHEDULED VISIT. THIS IS A CHARGE THAT IS NOT BILLED TO OR COVERED BY INSURANCE AND IS MY RESPONSIBILITY.
- I HEREBY GIVE ASSOC. EAR, NOSE & THROAT SPECIALISTS PERMISSION TO RELEASE MY RECORDS TO MY PRIMARY CARE PHYSICIAN LISTED ABOVE, AND TO MY INSURANCE COMPANY, INCLUDING PSYCHIATRIC, SUBSTANCE ABUSE AND AIDS-RELATED INFORMATION.
- I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN ACCESS TO A COPY OF THE NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT I MAY CONTACT THE OFFICE MANAGER IF I HAVE FURTHER QUESTIONS OR COMPLAINTS; I ALSO UNDERSTAND THAT I AM ENTITLED TO RECEIVE UPDATES UPON REQUEST, IF THE NOTICE OF PRIVACY PRACTICES IS AMENDED OR CHANGED.

Signature: _____ **Date: _____**

Medications / Release of Information

Allergies to Medications: _____ _____ _____ _____

Current Medications including vitamins, over-the-counter medications and supplements

Medication Name:	**Dosage:**	**Frequency:**	**Method/Route:** *(Oral pill, injection, etc)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Permission to Discuss Patient's Records

I, _____, give Dr. Todd Zachs,
(print name)
permission to discuss my medical condition and any pertinent medical information with the following people:

1. _____ _____
   Name Relationship

2. _____ _____
   Name Relationship

Patient Signature: _____ Date: _____

Name: _____ Birth date: _____

Please answer the following questions regarding your medical status and history:

1. Reason for today's visit: _____

2. Have you **ever** been treated for any medical conditions (Example: diabetes, high blood pressure, arthritis, etc.)? [ ] Yes [ ] No ***If yes, please explain:**

   _____

   _____

Height: _____ ft _____ Inches **Weight: _____ lbs**

Do you currently have any of the following? **If NO, please put an X / If YES, please Circle and Explain:**

Chronic fever, unexpected weight loss/gain, fatigue	No ____ Yes _____
Eye (e.g. glaucoma, cataracts, retinal disease)	No ____ Yes _____
Heart (e.g. chest pain, irregular heartbeat)	No ____ Yes _____
Respiratory (e.g. shortness of breath, wheezing)	No ____ Yes _____
Gastrointestinal (e.g. heartburn, abd pain, diarrhea)	No ____ Yes _____
Urinary (e.g. pain or discomfort, blood in urine)	No ____ Yes _____
Skin (e.g. skin cancer, rashes, excessive dryness)	No ____ Yes _____
Musculoskeletal (e.g. arthritis, swollen joints)	No ____ Yes _____
Neurological (e.g. numbness, weakness, headaches)	No ____ Yes _____
Psychiatric (e.g. depression, anxiety)	No ____ Yes _____
Endocrine (e.g. diabetes, hypothyroid)	No ____ Yes _____
Blood/Lymph (e.g. anemia, cholesterol problems)	No ____ Yes _____
Allergic/Immunologic (e.g. hay fever, lupus)	No ____ Yes _____
Hearing loss	No ____ Yes _____
Snoring, nosebleeds, runny nose	No ____ Yes _____
Sinus problems, sore throat, recurrent infections	No ____ Yes _____
Mouth sores, dryness, blisters	No ____ Yes _____

Have you ever had any surgery? If not within the past ten years, have you had an ENT related surgery prior? [ ] Yes [ ] No ***If yes, please explain:**

_____

_____

Family History:

Do any medical issues or diseases run in your immediate family (parents, siblings, children)? (E.g. heart disease, ear problems, hearing loss, sleep apnea, diabetes, high blood pressure, cancer, kidney disease, stroke, bleeding/immune disorder? [ ] Yes [ ] No ***If yes, please list family member and disorder:**

_____

_____

_____

Acknowledgement Form

Dr. Todd Zachs feels that patients presenting to our office with sinus, allergy, hearing, throat or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through an endoscopy, laryngoscope, cerumen removal (wax removal), etc. These examinations are a separate charge to insurance. These are essentially painless and in many cases, can be completed quickly. If we participate with your insurance company, you will be only obligated to pay any deductibles or co-payments that apply to this claim.

Please note some insurance companies may list these diagnostic procedures as "surgery" on the insurance remittance form you will receive.

These procedures have almost no risk and provide your physician with an excellent view of the areas involved. You also reserve the right to refuse any of these tests/services at any time.

Please sign below to acknowledge that you have read and understood the above.

_____ _____

Patient Name-Printed DOB

_____ _____

Patient Signature Date

**The above named patient was unable to physically complete these intake forms and needed assistance by one of our staff members. These forms were completed by*: _____

Patient Initials: _____ Date: _____

Name: _____ Birth date: _____

(Circle and Fill In)

Do you smoke? Yes or No (If yes) how much?

- How many _____
- Daily / Weekly / Monthly / Socially

If you answered NO above, have you smoked in the past?

- When did you quit? Date: _____or Number years ago? _____

Do you use smokeless tobacco?

- Yes, currently
- No, not currently but have in the past
- No, never

Do you drink alcohol? Yes or No (If yes) how much?

- How many _____
- Daily / Weekly / Monthly / Socially

If you answered NO above, have you drank in the past?

- When did you quit? Date: _____ or Number of years ago? _____

Influenza Immunization (FLU): Yes / No Date: _____

Pneumonia Vaccination: Yes / No Date: _____