West Jefferson
Ear, Nose & Throat
HEAD & NECK SURGERY

Please fill in ALL of the blanks below. Print out a hard copy and bring it with you to your appointment.

Appointment Date:_____ Time: _____

Patient Name: _____ Date of Birth:_____

Patient Social Security #:_____ Age:_____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary/Referring Physician: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone:_____ Alternate Phone: _____

Relationship to Patient: _____

PERSON RESPONSIBLE FOR FEES

Name (if not patient):_____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Primary Insurance Company:_____

Member ID #: _____ Group #: _____

Secondary Insurance Company: _____

Member ID #: _____ Group #: _____

My Pharmacy: _____

I have reviewed the above completed information and have verified that it is accurate and true to the best of my knowledge.
By selecting the above button, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this form

Date: _____

17-59883

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HEAD & NECK SURGERY

Name _____

DOB: _____

ALLERGIES TO MEDICINE: _____

MEDICATIONS (list all, including over the counter medications):

REVIEW OF SYSTEMS (please bubble in answers):
DO YOU HAVE/HAVE YOU HAD?

ENT

Hearing Loss	Yes	No
Dizziness	Yes	No
Noise Exposure	Yes	No
Water Exposure to Ears	Yes	No
Epistaxis	Yes	No
Sore Throat	Yes	No
Allergies	Yes	No
Snoring	Yes	No
Sinus Problems	Yes	No

NEUROLOGY

Memory Loss	Yes	No
Headache	Yes	No

CARDIOLOGY

Chest Pain	Yes	No
Palpitations	Yes	No
High Blood Pressure	Yes	No
Shortness of Breath	Yes	No

RESPIRATORY

Cough	Yes	No
Recent Bronchitis	Yes	No
Wheezing	Yes	No

ENDOCRINOLOGY

Diabetes	Yes	No
Weight Loss	Yes	No
Fatigue	Yes	No

DERMATOLOGY

Rash	Yes	No
Mole	Yes	No
Lumps	Yes	No

HEMATOLOGY/LYMPH

Easy Bruising	Yes	No
Swollen Glands	Yes	No

GASTROENTEROLOGY

Vomiting	Yes	No
Heartburn	Yes	No
Dysphagia	Yes	No

PSYCHOLOGY

Depression	Yes	No
Anxiety	Yes	No
Suicidal Ideation	Yes	No

1111 Medical Center Blvd. • Suite N-707 • Marrero, LA 70072 • 504.934.8550 • 504.934.8549 (fax) • wjmc.org/ent

West Jefferson
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HEAD & NECK SURGERY

Name _____

DOB: _____

REASON FOR VISIT:_____

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY

SOCIAL HISTORY (please bubble in answers):

Alcohol ○ Yes ○ No

Smoking
○ Current Smoker
○ Former Smoker
○ Non-Smoker

Passive Smoke Exposure ○ Yes ○ No

Sexually Active ○ Yes ○ No

Recreational Drug Use: ○ Yes ○ No

Exercise: ○ Yes ○ No

Caffeine: ○ Yes ○ No

Attend Daycare ○ Yes ○ No

FAMILY HISTORY (please bubble in answers):

	MOTHER	FATHER	CHILDREN
Hearing Problems	○	○	○
Hearing Aids	○	○	○
Meniere's Disease	○	○	○
Head and Neck Cancer	○	○	○
Cancer Elsewhere	○	○	○
Thyroid Problems	○	○	○
Parathyroid Problems	○	○	○
Diabetes	○	○	○
Seizure Disorders	○	○	○
Problems with Anesthesia	○	○	○
Bleeding Problems	○	○	○
Tuberculosis	○	○	○

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RELEASE OF INFORMATION

I hereby authorize West Jefferson Ear, Nose & Throat to furnish medical information concerning my present illness or injury to my family physician(s), referring physician(s) and insurance companies. I further authorize my family physician(s), referring physician(s) and other healthcare providers to furnish all medical information concerning my present illness or injury to West Jefferson Ear, Nose & Throat. I permit the doctor and his assistant to take photographs and any other digital images of the above named patient. I understand that these images are for legal documentation presentation at professional meetings or discussions, and give permission to use them as such.

RELEASE /CONSENT FOR TREATMENT

I voluntarily consent and authorize West Jefferson Ear, Nose & Throat and such associates, technical assistants and other health care providers, to treat my condition as they deem necessary. I understand that by signing below I am authorizing West Jefferson Ear, Nose & Throat and/or associates to perform any procedures, CT Scans, ultrasound scans necessary for my care. I agree that it is my responsibility to know and understand my insurance benefits and coverage thereof. I also understand that I will be responsible for any charges that my insurance company does not cover. I understand that no warranty or guarantee has been made to me as to the result or cure of my care.

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

I request that payment of the surgical and/or medical benefits, otherwise payable to me to be paid directly to West Jefferson Ear, Nose & Throat for services provided by them. I understand that I am financially responsible to West Jefferson Ear, Nose & Throat for charges not covered by this assignment of benefit, **including a $50.00 "no show" fee** for any and all missed, follow-up and new patient appointments that were not canceled by me at least 24 hours prior to the scheduled time; as well as any interest, collection fees and any reasonable attorney fees on delinquent accounts. I am also aware that I am solely responsible for my knowledge of my insurance benefits/coverage and for obtaining any and all referrals required by my insurance company and that I will be responsible for any payments on denied services resulting in the lack thereof. I am aware that payment for non-covered services, co-payments and deductibles are due at the time of service.

◉ I hereby authorize release of my medical information to the following persons:

By selecting the above button, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this form.

_____ _____

Patient Name (printed) Date

Please fill out the forms, print them, and bring them with you to your appointment. PRINT FORM

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