

New Patient Packet

This packet must be returned
2 days prior to your appointment !!

*In an effort to reduce waiting time in our office, we are requesting that you complete the attached New Patient Packet and return it **2 days prior to your visit.***

You can return it by:

Fax: 410-398-9597

Mail: 111 West High Street

Suite 303

Elkton, MD 21921

Att: New Patient Registration

(It must be received 2 working days before your appointment)

In Person: *You can return it to the office or slide it under the door **2 days prior** to your appointment.*

If you should have questions while completing the packet, please don't hesitate to call us for assistance.

Thank you for your help,

The Staff of Chesapeake ENT/FPS

WELCOME TO THE CHESAPEAKE ENT & FACIAL PLASTIC SURGERY

Chesapeake ENT & Facial Plastic Surgery is an Otolaryngology practice affiliated with Union Hospital. This list provides information about our services and answers to the most commonly asked questions.

APPOINTMENTS:

Every effort is made to see you at or close to your appointment time, so your promptness is appreciated. Unfortunately, unforeseen conditions of other patients or medical emergencies may require the doctor to spend extra time with a patient. When you schedule an appointment, please be as complete as possible in describing your needs so that we may schedule the proper amount of time for you. If you fail to cancel your appointment, you will be charged a \$25. "No Show Fee". This is necessary to insure courtesy to other patients.

INSURANCE:

Please bring a copy of your current insurance card and a photo ID. If your insurance plan requires a referral, please request it in advance from your Primary Care Physician.

IF YOU NEED A COPY OF YOUR MEDICAL RECORD:

The original medical record is the property of the health care provider. However, records will be copied for you or another healthcare provider with your written request. There may be a charge to copy records for your personal use.

IF YOU NEED A PRESCRIPTION REFILLED:

Requests to refill a prescription should be made at least one to two business days before the prescription runs out. Narcotic prescriptions and other controlled substances require a written prescription and will have to be picked up at the office.

IF YOU NEED A REFERRAL:

Please call your Primary Care Physician prior to your scheduled appointment. We are unable to bill your insurance without a referral. **If you arrive for your appointment without a referral you will be asked to reschedule your appointment or asked to sign a waiver making you financially responsible for the visit.**

PAYMENT:

Bounced checks increase the cost to ALL patients. As a consideration to our patients, our office will no longer accept personal checks. Payments will be accepted as cash, credit card and debit only.

Charges and co-payments are expected at the time of check-in. The administrative costs to bill small amounts results in added costs for all patients. Every effort is made to collect past due balances.

We look forward to meeting you!

Chesapeake ENT/FPS
Dr. David Martini Dr. Jagdeep Hundal
111 West High Street, Suite 303
Elkton, MD 21921

Name: _____ Sex: M F

Address: _____

City: _____ State _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Date of Birth: _____ Social Security #: _____

Primary Care Physician: _____

Phone #: _____ Fax #: _____

Pharmacy Name: _____

Phone #: _____ Fax #: _____

Emergency Contact/Guarantor of Patient Under 18 Years of Age:

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Insurance Card and/or Insurance Referrals must be presented at the beginning of the appointment. All insurance co-payments will be collected at the beginning of the appointment.

*By signing this form you are taking full responsibility for any charges that your insurance company will not cover.

Signature: _____

C>Welcome

ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Full Name _____ **Appointment Date** _____

What is the main reason you are seeing the doctor today? _____

Are you taking ANY kind of medication now? No Yes *If yes, please list below.*

(This includes prescription, over-the-counter or herbal medications)

| Medication Name | Dosage | How often taken |
|-----------------|--------|-----------------|
| | | |
| | | |
| | | |
| | | |
| | | |

ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes *If yes, please list below.*

| Name of Medication | Type of Reaction |
|--------------------|------------------|
| | |
| | |
| | |

Are you allergic to any type of food? No Yes *If yes, what reaction do you have?* _____

Are you allergic to any non-medical things such as latex, tape, metal or contrast dye? No Yes latex tape metal

Have you ever been DIAGNOSED with any of the following problems?

Head and Face:

- Cluster headache No Yes
- Migraine headache No Yes

Eyes:

- Cataracts No Yes
- Glaucoma No Yes

Ears:

- Hearing loss from aging No Yes
- Hearing loss from trauma No Yes

Nose and Sinus:

- Nasal Allergies No Yes
- Deviated Septum No Yes
- Chronic Sinus No Yes

Mouth and Throat:

- Chronic Tonsillitis No Yes
- Sleep Apnea No Yes

Heart and Blood Vessels:

- High / Elevated Cholesterol No Yes
- High Blood pressure No Yes

Lungs and Respiratory:

- Asthma No Yes
- Chronic Bronchitis No Yes
- Emphysema No Yes

Stomach and Digestive:

- Gallbladder Inflammation No Yes
- Gastrointestinal reflux No Yes
- Ulcerative colitis No Yes
- Stomach ulcer No Yes

Mental & Emotional:

- Depression No Yes
- Anxiety No Yes

Glands, Hormones, and Sugar Control:

- Diabetes No Yes
- Thyroid deficiency No Yes
- Thyroid excess No Yes

Allergies, Immune & Infectious Problems:

- HIV No Yes
- Infectious mononucleosis No Yes

- Are you pregnant? No Yes
- Cancer? No Yes

Other (not listed) _____

SURGERIES AND HOSPITALIZATIONS:

Have you had problems with anesthesia No Yes
 Have had any ear nose or throat surgery? No Yes (type and date) _____

List any other surgeries you have had _____

Have you ever been hospitalized for non-surgical reasons? No Yes
 If so please explain _____

FAMILY HISTORY

Ears:
 Hearing Loss before age 20 Mother Father Brother Sister
 Hearing Loss after age 20 Mother Father Brother Sister
Nose and Sinus:
 Chronic Sinus Disease Mother Father Brother Sister
Heart and Blood Vessels:
 Heart Disease Mother Father Brother Sister
 High Blood Pressure Mother Father Brother Sister

Lungs and Respiratory:
 Asthma Mother Father Brother Sister
 Lung Cancer Mother Father Brother Sister
Brain and Nervous:
 Stroke Mother Father Brother Sister
Blood & Lymph Node problems:
 Bleeding/clotting problem Mother Father Brother Sister
 Other _____ Mother Father Brother Sister

SOCIAL HISTORY

What is or was your occupation? _____

Have you ever used tobacco in any form? No Yes
 If yes, please complete the following:

| Type of Tobacco | From year | To year |
|---------------------------|-----------|---------|
| Cigarettes per day: _____ | | |
| Other: (list type) _____ | | |

Do you consume alcohol? No Yes
 If yes, please complete the following:

| Type of Alcohol | How Much | How often |
|-----------------|----------|-----------|
| | | |
| | | |

Do you consume alcohol? No Yes
 Do you use drugs recreationally? No Yes

REVIEW OF SYSTEMS: Mark yes or no and CHECK any of the following you have recently had

General health problems No Yes
 fever, sleeping problems, unintentional weight loss
Head or Face problems No Yes
 headache, face pain)
Eye problems No Yes
 blurred vision, loss of vision painful eye
Ear problems No Yes
 hearing loss, dizziness, ringing, painful ear
Nose and Sinus
 frequent colds, nosebleeds, runny nose, itchy nose
 sinus drainage
Mouth & Throat problems No Yes
 change in voice, snoring, sore throat, ulcers
Neck problems No Yes
 neck masses or lumps, pain, swollen glands
Heart or circulation problems No Yes
 blacking out or fainting, chest pain, irregular
 heartbeat, swelling of ankles
Lung or respiratory problems No Yes
 freq non-productive cough, freq productive cough,

shortness of breath, wheezing
Stomach problems No Yes
 abdominal pain, diarrhea, heartburn, nausea,
 vomiting
Bones, Joints and Muscles No Yes
 pain in back, painful joints, stiffness, swelling of
 joints
Brain or Nervous system problems No Yes
 change in alertness, loss of bladder control, loss of
 consciousness, severe face pain
Problems with Glands, Hormones No Yes
 increased appetite, increased fatigue, neck has
 enlarged, unwanted weight change
Problems with Blood or Lymph nodes No Yes
 bleeds excessively after injury, bruises easily
Problems with Allergies No Yes
 food intolerances, freq sneezing, hives, post nasal
 drainage, severe reaction to insect bites)
 Other (not listed) _____

Patient Record of Disclosures

In general, the HIPPA privacy act gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

- Home Telephone Cell Phone
- Leave a message with call back number only
- OK to leave a detailed message
- Written communication to my home address

And/or

- Work Telephone
- OK to leave a detailed message
- Leave a message with call back number only

You may discuss my medical information with the following people:

Patient's signature or Guardian of patient under 18 years of age

Date