SACRAMENTO
EAR | NOSE | THROAT
FACIAL PLASTIC SURGERY

**Please print neatly and fill out every item as accurately as possible**. Ask a staff member if you require assistance in filling out this form.

**Doctor:** ____________________ **Acct:** _______________________ **Date:**_________________________

| **Patient Information** | | **Guarantor/Responsible Party information** | |
|---|---|---|---|
| **Child's Name: First, Middle, Last** | | **Guarantor/Responsible Party Name: First, Middle, Last** | |
| **Child's Date of Birth:** | ☐ **Male** ☐ **Female** | **Date of Birth:** | ☐ **Male** ☐ **Female** |
| **Address (including zip):** | | **Address:** ☐ **Same as child** | |
| **Home Phone:** ( ) | | **Cell Phone:** ( ) | |
| **Emergency Contact Name:** **Relationship:** | | **Employer:** **Address:** | **Work Phone** ( ) |
| **Phone:** ( ) | | **Relationship to Patient: (for other please specify relationship)** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other** | |

**Email:** ____________________________________ **Preferred Language:** __________________________

**Race:** ________________________ **Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Other: ___________________

| **Primary Insurance Information** | **Secondary Insurance Information** |
|---|---|
| **Insurance name:** | **Insurance name:** |
| **Insurance ID:** | **Insurance ID:** |
| **Group or Policy Number:** | **Group or Policy Number:** |
| **Policy Holders Name:** | **Policy Holders Name:** |
| **Policy Holders Relationship to Patient:** | **Policy Holders Relationship to Patient:** |
| **Policy Holders Date of Birth:** | **Policy Holders Date of Birth:** |

**Primary Care Physician (Family Doctor)** ______________________________________________

**Referring Physician**__________________________________________________________________

**Medicare/Medi-Cal Lifetime Signature on File**:
I request that payment of authorized Medicare/Medi-Cal benefits be made on the patient's behalf to Sacramento Ear Nose and Throat Surgical Medical Group, Inc., for any services furnished the patient by the physician. I authorize any holder of medical information about the patient to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

**Private Insurance Authorization for Assignment of Benefits/Information Release:**
I, the undersigned, authorize payment of medical benefits to Sacramento Ear Nose and Throat Surgical Medical Group, Inc., for any services furnished the patient by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims of benefits. I also understand that in the event I have no insurance coverage, I am responsible for all billed charges.

_____________________________________ _____________________________
Responsible Party's Signature Date

***This document must be signed in the office.***



**CHILD**

*What is the reason for your child's visit today?* ___________________________________________

*How tall is your child?* ____________ *How much does your child weigh?* ____________

**List all current medications, including any over the counter (OTC) medications or supplements.**

☐ **Not taking any medications**

| Name of Medication and Dosage |
|---|
| |
| |
| |
| |
| |
| |
| |

**List any drug allergies or medicines your child cannot take.** ☐ **No known drug allergies**

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

***Has your child ever had allergy testing?***

☐ **No**
☐ **Yes**

**Has your child ever taken allergy shots?** ☐ **No** ☐ **Yes**
**Is your child currently taking shots?** ☐ **No** ☐ **Yes**

**Is your child allergic to any of the following?**

☐ **Latex** ☐ **Tape** ☐ **Foods** ______________________________________
☐ **Other** ______________________________________________________

## Tests & Immunizations

**Pneumonia Vaccine:** ☐ **No** ☐ **Yes: Date administered:** ______________________

**Pharmacy:** Name ____________________________ Address: ______________________________

Phone #: ____________________________ Fax #: ______________________________

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# Past Health History

***Please indicate any diseases or problems that your child has had or been diagnosed with by a doctor.***

☐ **No Major Illnesses**

| **Childhood Diseases** | **Congenital (Birth) Problems** | **Other Problems** |
|---|---|---|
| ☐ Chickenpox | ☐ Congenital Malformation | ☐ Acne |
| ☐ Measles | ☐ Down's Syndrome | ☐ Asthma |
| ☐ Mumps | ☐ Prematurity (# of weeks______) | ☐ Diabetes |
| ☐ Other ________ | ☐ Cystic Fibrosis | ☐ GERD/Reflux |
| | ☐ Other ______________________ | ☐ Sleep Apnea |
| | | ☐ Other __________ |

***History of any other condition not listed?*** ______________________________________________

**(For Teenage Female Patients)** ***Are you pregnant?*** ☐ **Yes** ☐ **No** ☐ **Possibly / Not Sure**

***Has your child had surgery?*** ☐ **No** ☐ **Yes** ____________________________________________
**(Please describe)**

***Serious injury?*** ☐ **No** ☐ **Yes** ______________________________________________
**(Please describe)**

# Family History

**Please list any of your BLOOD RELATIVES who have a history of any of the following and give their relationship to you:**
☐ **Family history unknown**

| | | | **RELATIONSHIP** |
|---|---|---|---|
| Problems/Complications with Anesthesia | ☐ No | ☐ Yes | ____________________ |
| Heart Problems (Including Hypertension) | ☐ No | ☐ Yes | ____________________ |
| Lungs | ☐ No | ☐ Yes | ____________________ |
| Bleeding/Clotting Problems | ☐ No | ☐ Yes | ____________________ |
| Glands/Hormones (Diabetes) | ☐ No | ☐ Yes | ____________________ |
| Cancer | ☐ No | ☐ Yes | ____________________ |
| | | | (Please describe |
| Other Major Health Problems | ☐ No | ☐ Yes | ____________________ |
| | | | (Please describe) |

# Social History

***Is your child currently attending school?*** ☐ **Yes** ☐ **No** ***What grade level?*** _______________

***Does your child use tobacco?*** ☐ **Never** ☐ **Quit** ☐ **Yes**

***Does your child use any other drugs?*** ☐ **No** ☐ **Not Sure** ☐ **Yes** _______________________
**(Please describe)**

**Please answer yes or no to any other SYMPTOMS that you have now or have had RECENTLY.**

| | | |
|---|---|---|
| | | **General:** |
| ☐ No | ☐ Yes | Fever |
| | ☐ Yes | Weight Loss |
| | | ☐ Planned ☐ Unintentional |
| | ☐ Yes | Weight gain |
| | ☐ Yes | Sleeping Problems |
| | ☐ Yes | Other: ____________________ |
| | | *(Please describe)* |
| | | **Eye Problems:** |
| ☐ No | ☐ Yes | Blurred Vision |
| | ☐ Yes | Double Vision |
| | ☐ Yes | Itching/Burning |
| | ☐ Yes | Other:____________________ |
| | ☐ Yes | *(Please describe)* |
| | | **Ear Problems:** |
| ☐ No | ☐ Yes | Dizziness |
| | ☐ Yes | Drainage |
| | ☐ Yes | Hearing Loss |
| | ☐ Yes | Infection |
| | ☐ Yes | Itching |
| | ☐ Yes | Pain |
| | ☐ Yes | Ringing |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Nose Problems:** |
| ☐ No | ☐ Yes | Nasal Congestion |
| | ☐ Yes | Itching |
| | ☐ Yes | Nosebleeds |
| | ☐ Yes | Postnasal Drainage |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Mouth Problems:** |
| ☐ No | ☐ Yes | Bad Breath |
| | ☐ Yes | Dryness |
| | ☐ Yes | Hoarseness or Other Voice Change |
| | ☐ Yes | Snoring |
| | ☐ Yes | Sore Throat |
| | ☐ Yes | Swallowing Difficulty |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Heart Problems** |
| ☐ No | ☐ Yes | Lightheadedness |
| | ☐ Yes | Chest Pain |
| | ☐ Yes | Irregular Heartbeat/Palpitations |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Lung Problems:** |
| ☐ No | ☐ Yes | Frequent Cough |
| | ☐ Yes | Difficulty Breathing/Short of Breath |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |

| | | |
|---|---|---|
| | | **Stomach/GI Problems** |
| ☐ No | ☐ Yes | Abdominal Pain |
| | ☐ Yes | Constipation/Diarrhea |
| | ☐ Yes | Excessive Gas |
| | ☐ Yes | Heartburn/Indigestion |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Urinary or Female/Male Problems** |
| ☐ No | ☐ Yes | Difficulty Starting/Stopping Stream |
| | ☐ Yes | Frequency/Urgency |
| | ☐ Yes | Incontinence |
| | ☐ Yes | Pain/Bleeding |
| | ☐ Yes | Other:____________________ |
| | | *(Please Describe)* |
| | | **Bone/Muscle problems:** |
| ☐ No | ☐ Yes | Painful Joints |
| | ☐ Yes | Pain/Stiffness in Neck |
| | ☐ Yes | Weakness |
| | | Other:____________________ |
| | | *(Please Describe)* |
| | | **Breast or Skin problems:** |
| ☐ No | ☐ Yes | Change in Moles |
| | ☐ Yes | Dry/Itchy Skin |
| | ☐ Yes | Rash |
| | ☐ Yes | Sores |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| | | **Brain or Nerve Problems:** |
| ☐ No | ☐ Yes | Change in Smell |
| | ☐ Yes | Change in Taste |
| | ☐ Yes | Change in Vision NOT Corrected with Glasses |
| | ☐ Yes | Memory Loss |
| | ☐ Yes | Headache |
| | ☐ Yes | Numbness |
| | ☐ Yes | Facial Pain |
| | ☐ Yes | Weakness |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| ☐ No | ☐ Yes | **Blood or lymph problems:** |
| | ☐ Yes | Excessive Bleeding |
| | ☐ Yes | Easy bruisability |
| | ☐ Yes | Neck Mass/Swelling |
| | | Other:____________________ |
| | | *(Please describe)* |
| ☐ No | ☐ Yes | **Immune Problems:** |
| | ☐ Yes | Hives |
| | ☐ Yes | Unusual Infections |
| | ☐ Yes | Other:____________________ |
| | | *(Please describe)* |
| ☐ No | ☐ Yes | **Other medical problem not listed:** |
| | | ____________________ |
| | | ____________________ |
| | | *(Please describe)* |



**CHILD**

Revised 5/20/2013