ROBERT B. CONTRUCCI, D. O.

SOUTHEASTERN EAR, NOSE, THROAT, SINUS CENTER

EAR, NOSE AND THROAT CONDITIONS
ALLERGIC SINUS DISEASE
HEARING DISORDERS • HEARING AIDS

IF THERE IS ANY PROBLEM FILLING OUT THIS FORM, PLEASE ASK FOR ASSISTANCE.

Name _____ **Birth Date** _____ **Date**_____

Occupation _____ **Birth Place** _____

FAMILY HISTORY:

Cancer	yes	no
Tuberculosis	yes	no
Diabetes	yes	no
Heart Disease	yes	no
High Blood Pressure	yes	no
Bleeding Problems	yes	no
Hearing Loss	yes	no

PERSONAL HISTORY:

Measles	yes	no	**Kidney Disease**	yes	no
Mumps	yes	no	**Gonorrhea**	yes	no
Chickenpox	yes	no	**Syphilis**	yes	no
Diphtheria	yes	no	**Anemia**	yes	no
Pneumonia	yes	no	**Epilepsy or seizures**	yes	no
Influenza	yes	no	**Migraine headaches**	yes	no
Heart Disease	yes	no	**Tuberculosis**	yes	no
Arthritis	yes	no	**Diabetes**	yes	no
Polio or Meningitis	yes	no	**Cancer**	yes	no
Fainting Spells	yes	no	**High Blood Pressure**	yes	no
Enlarged Thyroid	yes	no	**Low Blood Pressure**	yes	no
Bleeding Disorders	yes	no	**Nervous Breakdown**	yes	no
Herpes/Cold Sores	yes	no	**Asthma**	yes	no
Hepatitis	yes	no	**Hives or Eczema**	yes	no
Frequent infections	yes	no	**Frequent Sore Throat**	yes	no
Enlarged Glands	yes	no	**Frequent Colds**	yes	no
Circulation problems	yes	no	**Aids**	yes	no

HABITS:

Alcoholic beverages: **Never**_____ **Barely** _____ **Moderate** _____ **Daily** _____

Tobacco: **Cigarettes** _____ **Packs per day** ____ **Numbers of years** _____
Cigars _____ **Pipe** _____ **Snuff** _____ **Chewing Tobacco** _____

Is the environment in which you work loud or noisy? Yes no
Have you been exposed in the past to any loud or unusual noises? Yes no
Have you been in Military Services? Yes no

MEDICATIONS:

_____
_____
_____
_____

ALLERGIES: (List all including to medications, foods, tapes, etc) _____
_____
_____

SURGERY (List all operations) _____
_____
_____

Have you been hospitalized for any illness yes no
List reasons:

_____

Referring Doctor: _____
Reason for seeing doctor: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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EAR, NOSE, THROAT • ALLERGIC SINUS CONDITIONS
FACIAL PLASTIC SURGERY • HEARING AIDS
HEAD AND NECK SURGERY

Patient:	Last Name	First Name	
Address:	include City,State,and Zip Code	Apt. #	
Home Phone No.:	Date of Birth:	Age:	Sex:☐Male☐Female
Social Security Number:		Driver's License No.:	
Primary Language:		Employers Phone Number:	
Employer's Name & Address		Emergency Contact/Relationship to you	
Primary Insurance:		Secondary Insurance:	
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed		Who is your family physician:	

Payment is due when services are rendered. All copays, balance, and deductibles will be collected at time of service.

How will you be paying today? ☐Cash ☐Check ☐Credit Card

PLEASE COMPLETE IF THE PATIENT IS NOT THE INSURANCE POLICY HOLDER

Insured:	Last Name	First Name	
Address:	include City, State, and Zip Code	Date of Birth	
Phone No.:		Social Security No.:	
Responsible party Employer:		Driver's License No.:	
Employer Phone No.:			

IF YOU HAVE NO INSURANCE, PLEASE FILL OUT THE BOTTOM PORTION.

☐Father ☐Mother ☐Guardian

Responsible party Last Name:		First Name:	
Address: Include:City, State, and Zip Code		Date of Birth:	
Phone No.:	Social Security No.:		
Responsible Party Employer:			
Employer Phone No.:		Driver's License No.:	

IF YOU ARE COVERED BY INSURANCE, PLEASE PRESENT YOUR CARD AND REFERRAL.

AUTHORIZATION: I hereby authorize the physicain indicated above to furnish to insurance Carriers concerning this illness, and I hereby irrevocably assign to the Doctor all payment for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance and any collection fees that may be incurred.

Patient, Parent or Guardian Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name _____

Address _____

Telephone _____ Social Security _____

SECTION B: To the Patient - Please read the following statement carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change, our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Address: _____

Telephone: _____ Fax: _____

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____