

CY-FAIR ENT
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**** PLEASE FILL IN ALL BLANKS AND NO P.O. BOX ADDRESSES****

Last Name: _____ First Name: _____ MI: _____
DOB: ___/___/___ Age: ___ Marital Status: _____ Sex: M F SS# _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____

Referred By (Be Specific): _____ Phone: _____
Family Physician: _____ Phone: _____

In Case of Emergency: _____ Relationship: _____ Phone: _____

When we cannot reach you directly, you may authorize us to release information to the following individuals:

Name	Relationship	Phone	General Messages	Normal Lab	Detailed Info
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE INFORMATION

Insurance Company: _____
Subscriber's Name: _____ Relationship to Patient _____
DOB: ___/___/___ SS# _____ ID# _____ Grp# _____

PATIENT HISTORY

Do you have or have ever had any of the following health problems? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus/Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma/Lung Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorders/Anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Complications with anesthesia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other _____ | | |

List any medications including herbs, vitamins, birth control, aspirin that you take on a regular basis (Specify Dosage):

List any medications you are ALLERGIC to:

List hospitalization and SURGERIES (Including Dates):

List any X-RAYS, CT, OR MRI relative to your current condition:

List any medical problems in your family:

Have you ever smoked cigarettes? Yes No
Do you still smoke? Yes No
Do you chew Tobacco? Yes No

If so how long? _____ Packs/Day: _____
When did you stop smoking? _____
If so, how long? _____