VANAN ENT+ SINUS CENTER

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

FAMILY DOCTOR _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ___/___/_____ RACE _____

ENGLISH ☐ OTHER _____ HERITAGE _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

E-MAIL _____

SOCIAL SECURITY # _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER/OCCUPATION _____

REFERRING PHYSICIAN _____

EMERGENCY CONTACT

NAME _____ HOME PHONE _____

RELATIONSHIP WORK PHONE _____

IF MARRIED, SPOUSE INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____ SSN _____

EMPLOYER _____ WORK PHONE _____

IF MINOR (UNDER THE AGE OF 18) WHO IS FINANCIALLY RESPONSIBLE? ☐ MOTHER ☐ FATHER

MOTHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

FATHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/____ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/____ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

CO-PAY _____ POLICY NUMBER _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESSS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

The patient or representative, recognizing the need of medical care and/or evaluation, consents to services as ordered by the attending physician including local anesthesia, laboratory procedures, medical treatment, minor or emergency surgical treatment, radiology procedures, physical examination, or other services rendered under the general and specific instructions of the physician.

_____

SIGNATURE (Patient or Parent if Minor) DATE

VANAN ENT+ SINUS CENTER
801 Pro Drive, Celina, OH 45822
Phone: 419.586.6480
Fax: 419.586.8509

Patient Name: _____

Consent for Notification

1. If we call you at home and you are not available, may we leave information such as positive/negative test results, appointments, billing matters and health care information with another person?

   _____YES _____NO

   If YES, please state name of person (s) and relationship:

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

2. If you have an answering machine at home, may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your answering machine does not identify yourself, we will not leave a detailed message.

   _____YES _____NO

3. If you have a cell phone may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your cell phone voice mail does not identify yourself, we will not leave a detailed message.
   ** I am fully aware that a cellular telephone is not a secure line and private line.

   _____YES _____NO

If the above answers are NO, how is the best way to contact you? _____

_____
Patient Name (Please PRINT)

_____ _____ _____
Patient Date of Birth Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

This Authorization is valid until you inform our office otherwise in writing.

VANAN ENT+ SINUS CENTER

NEW PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

YOUR ALLERGIES – Please indicate reaction if there is a positive allergy:

☐ Dairy	☐ Tylenol	☐ Adhesive Tape	☐ Animal Dander
☐ Eggs	☐ Aspirin	☐ Cosmetics	☐ Dust
☐ Grains/Wheat	☐ Codeine	☐ Detergent	☐ Grass
☐ Nuts/Peanuts	☐ Sulfa Drugs	☐ Latex	☐ Insect bites/Stings
☐ Shellfish	☐ NSAIDS	☐ Metals	☐ Mites
☐ Strawberries	☐ Penicillin	☐ Molds/Mildew	☐ Pollen

Please list any other allergies you may have: _____

_____

YOUR MEDICAL HISTORY – Please check if you have of these diagnoses:

☐ Alcohol Abuse	☐ Cancer: type _____	☐ High Blood Pressure	☐ Glaucoma
☐ Anemia	☐ Depression	☐ High Cholesterol	☐ Vision Impairment
☐ Arthritis	☐ Diabetes	☐ Liver Disease	☐ Hearing Impairment
☐ Asthma	☐ Drug Abuse	☐ Lung Disease	
☐ Bleeding Disorders	☐ Epilepsy	☐ Mental Disorder	
☐ Migraines	☐ Stroke	☐ Thyroid Disorder	

Other medical problems: _____

FAMILY MEDICAL HISTORY – Please indicate who has this in your family (Parents, Grandparents, Siblings)

	Mom	Dad	Brother	Sister	Grandparent
Arthritis					
Asthma					
Bleeding Disorder					
Cancers					
Diabetes					
Heart Disease					
High Cholesterol					
Kidney Disease					
Liver Disease					
Mental Illness					
Seizures					
Alcohol Abuse					
Drug Abuse					
Thyroid Disorder					
Tuberculosis					
Birth Defects					
Genetic Disorders					

Other _____

SPECIALIST NAME/LOCATION:
Cardiologist: _____
Nephrologist: _____
Pulmonologist: _____
Neurologist: _____

SURGICAL HISTORY – Please list all your surgeries and the date they were done.

_____
_____

YOUR SOCIAL HISTORY
Marital Status ☐ Single ☐ Married ☐ Committed Relationship ☐ Separated ☐ Divorced ☐ Widowed

Culture/Language: _____

Living situation: ☐ Alone ☐ with spouse/partner ☐ with family ☐ Group Home ☐ Nursing Home

Occupation: _____ ☐ Retired ☐ Currently unemployed

Do you drink alcohol? ☐ YES ☐ NO
If yes, how much alcohol do you consume in a week? _____

Do you smoke? ☐ YES ☐ NO
If yes, how many packs per day _____ For how many years? _____

Are you a former smoker/any other tobacco use (cigar, vaping, chewing)
☐ YES ☐ NO How many years did you smoke? _____
When did you quit? _____

Do you use street drugs? (marijuana, cocaine, heroin, etc.) ☐ YES ☐ NO

Have you used street drugs in the past ☐YES ☐ NO

Do you have any tobacco smoke exposure? ☐ YES ☐ NO

How much caffeine do you drink daily? _____ cups per day ☐ I do not drink caffeine
Circle: Pop, coffee, tea, energy drink

Do you have pets living in the home? ☐ YES ☐ NO
Please list the types of pets: _____

YOUR MEDICATIONS – Please include the name of the medication, dose, and instructions.

Pharmacy Name/Location:
Signature: