WELLENDORF ENT PATIENT INFORMATION

Pharmacy of Choice________________________________ Location ____________________________

Patient ____
Last First M.I

Date of Birth_____/_____/______ Age_______ Sex M F Preferred Name___________________

Social Security Number_______________________ Primary Language Spoken____________________

Race (Circle One) American Indian/Alaska Native Asian Black/African American White Other Declined
Ethnicity (Circle One) Hispanic or Latino Not Hispanic or Latino Declined

Marital Status: S M D W Spouse Name _______________________ DOB ____/______/________

Mailing Address:
____
Street
____
City State Zip

Home Phone Number:_____________________ Cell Phone Number ________________________

Preferred Way to be contacted **(circle one):** Declined Home Cell

Family Physician________________________ Referring Physician_____________________________

Person Responsible for Bill: ___________________________ Relationship to Patient __________________

Responsible Person Address ____

Responsible Person DOB ____/______/________ Social Security ______-_________-__________

Phone Number _______________________ Cell Number ________________________

Person Responsible for Bill: ___________________________ Relationship to Patient __________________

Responsible Person Address ____

Responsible Person DOB ____/______/________ Social Security ______-_________-__________

Phone Number _______________________ Cell Number ________________________

PRIMARY INSURANCE_____________________ SECONDARY INSURANCE________________________

INVITATION TO P A T I E N T PORTAL

We are required to ask everyone for an email address so you may access your patient portal.

Are you able to provide an email? ___ Yes ____No

Patient Name: ________________________________

Email Address____

PATIENT OR AUTHORIZED PERON'S SIGNATURE ______________________________ DATE __________

PATIENT NAME ____ DOB______________________

REASON FOR TODAY'S VISIT:____

WHAT MAKES IT BETTER: ____ Worse______________________________

CURRENT MEDICATIONS
DO YOU TAKE ASPIRIN DAILY? _____Y ______N

List all the medications you are currently taking. Include over the counter, herbal, and medications that you take only occasionally. ____

Medications prescribed for complaint____

Are you Allergic to any medication? Y N If yes, please list: ___________________________________

ALLERGIES	SELF ____FAMILY___	HIV/AIDS	SELF____FAMILY___
ANEMIA	SELF ____ FAMILY ____	INDIGESTION	SELF ____FAMILY___
ARTHRITIS/JOINT PAIN	SELF ____ FAMILY ____	IRREGULAR HEART	SELF ____FAMILY___
ASTHMA	SELF ____ FAMILY ____	JAUNDICE	SELF ____FAMILY___
BLEEDING DISORDER	SELF ____FAMILY___	KIDNEY DISEASE	SELF ____FAMILY___
CHEST PAIN	SELF ____FAMILY___	NIGHT SWEATS	SELF ____FAMILY___
CONVULSION	SELF ____FAMILY___	NOSEBLEEDS	SELF ____FAMILY___
COPD/EMPHYSEMA	SELF ____FAMILY___	PACEMAKER	SELF ____FAMILY___
COUGH	SELF ____FAMILY___	SHORTNESS OF BREATH	SELF ____FAMILY___
COUGHING BLOOD	SELF ____FAMILY___	SINUSITIS	SELF ____FAMILY___
DIABETES	SELF ____FAMILY___	SKIN CANCER	SELF ____FAMILY___
DIFFICULTY SWALLOWING	SELF ____FAMILY___	STROKE	SELF ____FAMILY___
DIZZINESS	SELF ____FAMILY___	THYROID DISEASE	SELF ____FAMILY___
EPILEPSY	SELF ____FAMILY___	TONSILLITIS	SELF ____FAMILY___
GLAUCOMA	SELF ____FAMILY___	TUBERCULOSIS	SELF ____FAMILY___
HEARING LOSS	SELF ____FAMILY___	ULCER	SELF ____FAMILY___
HEART DISEASE	SELF ____FAMILY___	VISION CHANGES	SELF ____FAMILY___
HEPATITIS	SELF ____FAMILY___	WEIGHT LOSS	SELF ____FAMILY___
HIGH BLOOD PRESURE	SELF ____FAMILY___	OTHER	SELF ____FAMILY___

FAMILY HISTORY:

Do you know of any inherited diseases or bleeding disorder in your family? ______________________________

SURGICAL HISTORY: ______ Appendix _____ D&C ____Ear Surgery ____Gallbladder ____Heart Surgery _____Heart Stent

___ Hysterectomy ________ Joint Replacement _____Nasal Surgery ______ Prostate ______Thyroidectomy

____Tonsils/Adenoids ________ No Prior Surgery

____Other ______________________________ Complications with Anesthesia? ____________________________

PHYSYCOSOCIAL HISTORY:

Pediatric Only: Are Immunizations up to date? ___Yes ___No

Do you consume alcohol? ___ Yes ___ No If yes, how much/often?_________

Tobacco Use: ___Current ____Former ____Never if yes: ___Smoke ___Chewing Tobacco

Age started______ Age Stopped ________ Are you pregnant? ____Yes _____ No

Do you take recreational drugs? _______________________________

What kind of work do you do? _______________________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE ____

WELLENDORF ENT

HIPAA RELEASE FORM

(please fill out)

Patient Name: ______________________________ Date of Birth: ____________

With whom may we speak to in regards to your medical care (spouse, parents, grandparents, and children?)

Name: ______________________________ Phone ____________________

Name ______________________________ Phone ____________________

Name ______________________________ Phone ____________________

Signature ______________________________ **Date** ____________________

** If you are a minor and are under 18, you MUST be accompanied by a parent or court- appointed legal guardian,

in order for us to treat**

PHARMACY BENEFIT MANAGEMENT (PBM) CONSENT FORM (E)LECTRONIC-PRESCRIBING

E-PRESCRIBING- is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy.

MEDICATION HISTORY TRANSCATIONS- Provides the physician with information about medications that the patient is already taking prescribed by a provider, to minimize the number of adverse drug events.

By signing this consent, you are agreeing that WELLENDORF ENT P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

______________________ ______________________

Patient Name (print) Patient DOB

____

Patient or Authorized Signature

☐ I Deny Consent

______________________ ______________________

Patient Signature Date