Lauren C. Anderson, MD, FACS
NRMC ENT

Pediatric New Patient Intake Form

Patient Information:

Shaded area very important:

Last Name: ________________________ First Name: _________________________ DOB: ______________________

Home Phone: _____________________ Mobile Phone: _______________________ SSN: ______________________

Address: ____

Preferred (circle): Home / Cell Email: ____________________________________ Gender: ____________________

Primary Pediatrician: ____ Pharmacy: _________________________

Referring Provider (who sent you to us?): ____

Parent 1 Name: ____ Date of Birth______________________

Social Security# _______________________________ Phone: ____________________________

Occupation: ________________________________ Email: ____

Marital Status: _____________________________ Spouse: ____

Parent 2 Name: ____Phone: ____________________________

Occupation: ______________________________ Email: ____

Marital Status: ____________________________ Spouse: ____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- ◻ Decline Response
- ◻ Hispanic or Latino
- ◻ Not Hispanic or Latino

Race:
- ◻ Decline Response
- ◻ American-Indian or Alaska Native
- ◻ Asian
- ◻ Black or African American
- ◻ Native Hawaiian or Pacific Islander
- ◻ White
- ◻ Other

Preferred Language: ____ ◻ Decline Response

____ I have read, understand and agree to the Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

____ I authorize my insurance benefits be paid directly to **NRMC ENT**. In the event my claim is denied, I authorize **NRMC ENT** to file an appeal on my behalf.

____ In order to properly treat me, I authorize **NRMC ENT** permission to view my prescription medication records.

____ I authorize **NRMC ENT**, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

____ I authorize **NRMC ENT** to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

____ I also understand that certain procedures and tests performed in this office are not included in the standard office visit. Some of the procedures are classified as "surgery" by my insurance carrier and that the charges may go towards my deductible. This includes, but is not limited to, flexible laryngoscopy, nasal endoscopy, cerumen removal and audiometric testing.

____ I understand that a missed appointment is when I fail to show up for an appointment, cancel less than 24 hours prior to your scheduled appointment, or arrive more than 15 minutes late. After my third missed appointment, I understand that I
will be discharged from the clinic.

____ I acknowledge that I was given the opportunity to obtain a copy of **NRMC ENT's** privacy practices.

____ I authorize **NRMC ENT** to contact or discuss my personal health information with:

Name: ______________________________________ Relationship: __________
Name: ______________________________________ Relationship: __________

Patient or Legal Guardian Name (Print): ____

Patient or Legal Guardian Signature: ______________________________ Date: __________

Medical and Social History

Reason for today's visit: ____

____

Is patient adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*

Which pregnancy is patient? _______ Birth weight: _____ Born by: □ C-Section □ Vaginal
Weeks' gestation at birth? _______ If C-section, why? ____
Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

____

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? □ Y□ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Please list ALL current medications, including over-the-counter, supplements, and herbs: □ I don't know my medications.

Medication Name	Dose

Medication Name	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Procedure/Hospitalization	Date	Reason	Complications

Has the patient EVER had any of the following?

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Anemia/Bleeding tendency ....□ Y □N
Asthma/Breathing problems ....□ Y □N
Behavioral problems.................................□ Y □N
Blood Transfusion....................................□ Y □N
Bowel/Stomach problems ....□ Y □N
Cancer/Leukemia ....□ Y □N
Chicken Pox/Shingles ....□ Y □N
Developmental disorder ....□ Y □N
Diabetes ....□ Y □N

Ear/Nose/Throat ....□ Y □N
Eczema/Skin disorder ....□ Y □N
Eye Disorder ....□ Y □N
Growth disorder.......................................□ Y □N
Heart disorder/defect ....□ Y □N
Kidney/Bladder problems ....□ Y □N
Liver disease ....□ Y □N
Seizure or Epilepsy ....□ Y □N
Thyroid disorder ....□ Y □N

Please provide details for any of the above conditions answered "yes" or any other conditions not mentioned:

Please indicate any major conditions/illnesses that the patient's immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Parent:		□ Y □ N	
Parent:		□ Y □ N	
Sibling:		□ Y □ N	
Other:		□ Y □ N	

Please provide details of siblings and other individuals in the household:

Name	Age	Gender	Relationship to patient

Patient Social History

Does anyone living in your home smoke? □ Y □ N Pets? □ Y □ N **Females**: Menses? □Y □N Age? ________

Do you smoke? □Y □N □Never If Y, Packs/day _______ If N, previously? □Y □N Yrs. smoked _____ Packs/day ____

Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If Y, drinks/week _______

Street drugs? □Y □N If Y, what? ____________________ If N, previously? □Y □N and what? ______________________

OFFICE USE ONLY:

Provider Signature: ____ Date: ______________________________________

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