Berkshire Ear, Nose, Throat & Audiological Associates, P.C.

**First Name**: ___________________________ **Middle**: ______________**Last Name**: ___________________________

**Address:** ________________________________________ **City**: __________________ **State**: _________ **Zip**: ______

**Home Phone**: (____) _____-_____ **Work:** (____) _____-______ Cell: (____) _____-______

**SSN#**________________________ **Date of Birth:** ______/_______/________ **Gender:** ☐ Male ☐ Female

**Race:**
- ☐ White
- ☐ African American
- ☐ Hispanic
- ☐ Asian
- ☐ Other: ______________

**Ethnicity:**
- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin

**Preferred Language:**
- ☐ English
- ☐ Spanish
- ☐ Other: ______________

**With whom do you allow us to discuss your care?** ____________________________________________________

**Employer:** _______________________________________ **Occupation:** ____________________________________

**Emergency Contact:** ______________________________ **Phone #** (_____) ______- _________________________

**Primary Physician**: _______________________________ **Referring Physician**: _____________________________

**Pharmacy**: _______________________________________ **Pharmacy Location**: _____________________________

**Email Address**: _____________________________________________________________________________________

**Billing Information:**

**<u>Primary Insurance</u>:** ____________________________________ **Subscriber:** ____________________________

**Subscriber ID#:** _______________________________________

**<u>Secondary Insurance</u>:** _________________________________ **Subscriber:** ____________________________

**Subscriber ID#:** ________________________________________

**<u>Tertiary Insurance</u>**: ____________________________________ **Subscriber:** ____________________________

**Subscriber ID#**: ________________________________________

**I authorize release of any information necessary to process my insurance claim, assign payment directly to Berkshire Ear, Nose, Throat and Audiological Associates, P.C., and acknowledge that I am financially responsible for any unpaid balance. I acknowledge that I have been provided a copy of the practices Notice of Privacy Practice.**

**Signature**: ________________________________________________________________ **Date**: _________________

**MEDICATION NAME AND DOSAGE:** **WHY ARE YOU TAKING THIS MEDICATION?**

| MEDICATION NAME AND DOSAGE | WHY ARE YOU TAKING THIS MEDICATION? |
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| | |
| | |
| | |
| | |
| | |
| | |

**ASPIRIN: ____YES ____NO _____QUANTITY PER DAY_____HOW MANY YEARS**

**MEDICATION ALLERGIES:** **None: ______**

___

___

___

**PAST MEDICAL HISTORY/MEDICAL CONDITIONS:** **None: ______**

___

___

___

___

**LAST TB TEST: _____POS______NEG_____NOT TESTED**

**SURGERIES OR HOSPITALIZATIONS:** **None: ______**

___

___

___

___

**FAMILY HISTORY- PLEASE LIST MEDICAL PROBLEMS OF RELATIVES:**

| Family History | Father | Mother | Brother | Sister |
|---|---|---|---|---|
| Diabetes | | | | |
| Heart Disease | | | | |
| Hearing Loss | | | | |
| Cancer (what kind?) | | | | |
| Other | | | | |

**SOCIAL HISTORY-Please check appropriate boxes and fill in accurate amounts**

**EXERCISE:** ☐ LIGHT ☐ MODERATE ☐ HEAVY HOURS PER WEEK: ______ TYPES OF EXERCISE: ______________

**CAFFEINE:** ☐ NONE ______ CUPS PER DAY ______ HOW MANY YEARS ____________________ OTHER

**ALCHOHOL:** ☐ NEVER ☐ BEER(S) ______PER WEEK ☐ LIQUOR______PER WEEK ☐ WINE______PER WEEK

**SMOKING:** ☐ NEVER

☐ CURRENT ______QUANTITY ______HOW MANY YEARS

☐ DISCONTINUED, IF DC'D WHEN______QUANTITY_______HOW MANY YEARS

☐ OTHER SMOKER'S IN THE HOME (SECONDARY SMOKE EXPOSURE)

**PATIENT NAME: ____________________________________________________________________**