

Patient Name		Date of Birth	Social Security #
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Street Address	City, State and Zip	Email Address
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Home Phone	Work Phone	Cell Phone	Preferred Contact Number <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell
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Mom's Name	Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="text"/>
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Dad's Name	Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="text"/>
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Guardian's Name if other than Mom or Dad	Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="text"/>
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If needed, use the back page to provide additional information.

Gender Male Female

Ethnicity Non Latino- Hispanic Latino -Hispanic

Preferred Language (if other than English)

Race American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White More than 1 Race Unknown/Not Reported

Complete this section for the person who is financially responsible for this patient.

Guarantor's Name	Relation to Patient	Date of Birth	Phone Number
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Address	City State and Zip
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Is your child covered by Insurance? Yes No

Does the Primary Insurance have a Deductible? Yes No If Yes, Has the deductible been met for the current year? Yes No

Please list all medical coverages for which you are eligible below. Use back of page if needed).

Primary Insurance Name	Primary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
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Primary Insurance Policy Holder	Policy Holder Date of Birth	Relation to Patient
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Secondary Insurance Name	Secondary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
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Secondary Insurance Policy Holder	Policy Holder Date of Birth	Relation to Patient
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Please List other Medical Providers Providing Care to your child.

Primary Care Physician Name	PCP Phone	Provider 2 Name	Provider 2 Phone
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Would you like access to our confidential website to access billing statements, appointment and medication requests? Yes No
If Yes, would you like your billing statements sent: By Email By Mail

Were you referred to our office by: Emergency Room Primary Care Other

Is your visit today related to a No Fault or Disability Injury? Yes No

Is your visit today about an injury that related to: Motor Vehicle Accident Altercation

Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to Albany ENT & Allergy Services PC and acknowledge that I am financially responsible for appropriate deductibles, copayments and non-covered items, including those charges which have been denied by my insurance carrier. I understand it is my responsibility to verify with my insurance plan that medical services provided by Albany ENT & Allergy Services will be covered by my plan. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company and health care provider(s) in accordance with HIPAA guidelines.

Signature of Patient or Guarantor: _____ Date: _____

Past Medical & Surgical History

Allergy/Immunology

None, if checked skip to next section

Allergies (Not Related to Medications)

If Yes, Please Mark/Describe Yes No

- Adhesive Tape Bees/Insects Eggs Environmental
 Food Latex Milk Peanuts
 Seafood Seasonal

Others:

Reaction to Anesthesia? Yes No
 General Local

If Yes, describe

Reaction to X-Ray Dye? Yes No
If Yes, describe

- Atopic Eczema Yes No
Contact Dermatitis Yes No
Eczema/Psoriasis Yes No
Hay Fever Yes No
Immunizations - Up to Date? Yes No
Juvenile Rheumatoid Arthritis Yes No

Birth and Developmental History

Complete this Section for Patients Age 1 - 3

- Anemia Yes No
Developmental Milestones
Turns to Sound (4 Months) Yes No
Responds to Name (6 Months) Yes No
Mama/Dada (9 Months) Yes No
Walk Alone (12 month) Yes No
Two Word Sentence - (2 Yrs) Yes No
Full Term Healthy Infant Yes No

If no, describe

Infections at Birth Yes No

If yes, describe

ICU Admission Yes No

NICU Stay Yes No

If yes to ICU or NICU describe

Passed Hospital Hearing Screen Yes No

Other Birth History

Cardiovascular None If checked skip to next section.

- Cardiac Arrhythmia Yes No
Heart Murmur Yes No
/Mitral Valve Prolapse Yes No
If Yes, Do you require antibiotic prophylaxis for procedures? Yes No
Patent Ductus Arteriosus (PDA) Yes No

Genetic None If checked skip to next section.

- Cystic Fibrosis Yes No
Down's Syndrome Yes No
Turner's Syndrome Yes No

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Dermatologic

- Birth Mark Yes No
Hives/Urticaria Yes No

Ear, Nose & Throat

- Adenoidectomy Yes No
Ear Infections Chronic Recurrent Yes No
Ear Wax, Recurrent Yes No
Ear Tubes Yes No
Frenulectomy Yes No
Hearing Loss Yes No
Nasal Fracture Yes No
Other Ear Surgery Yes No
Perforated Ear Drum Yes No
Swimmer's Ear Yes No
Tonsil Enlargement Yes No
Tonsillectomy Yes No
Tonsillitis Yes No
Upper Respiratory Infections, Frequent Yes No
Sinusitis Yes No
Vocal Cord Nodules Yes No

Gastrointestinal None If checked skip to next section.

- Appendectomy Yes No
Food Sensivity Yes No
Chronic Constipation Yes No
Formula Intolerance Yes No
GERD Yes No
Hernia Yes No
Hernia Repair Yes No
Jaundice Yes No
Lactose Intolerance Yes No
Heartburn/Reflux Yes No
Obesity Yes No
Hepatitis Yes No
Stomach Ulcer Yes No

Hematology None If checked skip to next section.

- Anemia Yes No
Bleeding Disorder Yes No
Sickle Cell Anemia Yes No
Hemophilia Yes No
Sickle Cell Trait Yes No
Thalassemia Yes No

Infectious

- Croup Yes No
HIV Yes No
Lyme Disease Yes No
Methicillin-Resistant Staphylococcus Aureaus (MRSA) Yes No
Pertussis Yes No
Respiratory Syncytial Virus (RSV) Yes No

Metabolic/Endocrine

- Diabetes Mellitus Type I Yes No
Obesity Yes No

Past Medical History (continued)

Neurology

- ADD/ADHD Yes No
Autism/Autism Spectrum Disorder Yes No
Developmental Delay Yes No
Headaches Yes No
Seizure Disorder/Epilepsy Yes No
Scoliosis Yes No
Tourette's Syndrome Yes No

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Pulmonary

- Asthma Yes No
Aspiration Pneumonia Yes No
Bronchitis Yes No
Laryngospasm Yes No
Pneumonia Yes No
Misc
Tooth Decay Yes No

Past Birth or Medical History Not Listed Above (Use back of page to continue if needed)

Home Environment & Habits

Is there secondhand smoke exposure at home? Yes No

Are there animals in the home? Yes No If Yes, Dog Cat Bird

Other Pets

Home Heating and Cooling:

Gas Hot Air Electric Wood Air Conditioning at Home? Yes No If Yes, Central Air Room

Oil Propane Solar Other Heat

Does your child sleep well on a regular basis? Yes No

If no, describe

Does your child drink beverages containing caffeine? Yes No

If Yes, how much?

Does your child drink water on a daily basis? Yes No

Amt Per Day

Does your child attend day care? Yes No

Pre School Age Children Only

If Yes, how many days per week?

Medications & Allergies

Is your child currently taking any medications? Yes No

If Yes, Please List Current Medications Below (over the counter and prescription) Use back of page for additional room.

Does your child have any medication allergies? Yes No

If Yes, Please List all Known Allergies below:

Local Pharmacy

Mail Order Pharmacy

Local Pharmacy Name	Local Pharmacy Phone	Mail Order Pharmacy Name	Mail Order Pharmacy Phone

Parent or Guardian's Signature: _____ Date: _____