



PATIENT INFORMATION, MEDICAL HISTORY & LIFETIME SIGNATURE

Please Print

DATE SOCIAL SECURITY # Chart #
NAME HOME PHONE CELL
ADDRESS-Street: APT#
CITY: STATE: ZIP: AGE: BIRTH DATE:
Check appropriate box: Male Female Minor Single Married Divorced Widowed Separated
Patient's or Parent/guardian's employer: Work Phone:
Business Address City State Zip
Occupation In case of an emergency contact Phone
Person responsible for this account Relationship to patient
Drivers License# Is this person currently a patient in this office? Yes No

*INSURANCE INFORMATION

Primary INSURANCE CO. Policy# Group#
Name of Insured Relationship to pt. Insured D/O/B SS#
Insurance Co. address City State Zip
Name of Employer Address of Employer
City State Zip Phone#
How much is your deductible? \$ How much have you used? \$ Co. Pay Amount \$

Secondary INSURANCE CO. Policy# Group#
Name of Insured Relationship to pt. Insured D/O/B SS#
Insurance Co. address City State Zip
Name of Employer Address of Employer
City State Zip Phone#

Please answer "YES" or "No" to the following questions:
Were you involved in an auto accident? If yes date of injury Are you covered by Auto Ins.?
Do you have an Attorney? Attorney Name Attorney Phone #

How did you come to this office? (Please check appropriate box)
Ins. Company/Book
Newspaper Radio TV Magazine Web Florida Panthers Bank Atlantic Center
Yellow Pages Friend /Patient Physician Other

The undersigned acknowledges and understands that South Florida Sinus and Allergy Center, Inc. relies on the information provided herein. The undersigned represents, warrants, and certifies that the information provided herein is true, correct and complete. The undersigned assumes liability if insurance does not pay due to his or her lack of disclosure or information.

(Print) Patient Name

(Signature) Patient Name

MEDICAL HISTORY

Patient Name _____ Pt. D/O/B _____ Chart # _____

What are we seeing you for: _____

Name of Current Physician _____ Phone Number _____	Name of Current Physician _____ Phone Number _____
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Have you ever had the following: (Circle "NO" or "YES")

Pneumonia	NO	YES	Migraine Headache	NO	YES	Hives/Eczema	NO	YES
Cancer	NO	YES	Tuberculosis	NO	YES	AIDS	NO	YES
Asthma	NO	YES	Diabetes	NO	YES	HIV+	NO	YES
Arthritis	NO	YES	Bleeding Tendency	NO	YES	Infectious Mono	NO	YES
Anemia	NO	YES	Nose Bleeds	NO	YES	Stroke	NO	YES
Epilepsy	NO	YES	High Blood Pressure	NO	YES	Hepatitis A	NO	YES
Sinusitis	NO	YES	Visual Problems	NO	YES	Hepatitis B	NO	YES
Hearing Loss	NO	YES	Rheumatic Fever	NO	YES	Hepatitis C	NO	YES
Tonsillitis	NO	YES	Heart Disease	NO	YES	Thyroid Disease	NO	YES
Hoarseness	NO	YES	Mitral Valve Prolapse	NO	YES	Kidney Disease	NO	YES

Any other disease please list: _____

Please list all CURRENT MEDICATIONS you now take (include non-prescription): _____

When did you last use ASPRIN/ANTI-INFLAMMATORY medicine? _____

Please list any and all "ALLERGIES TO MEDICATIONS": _____

Previous Hospitalization / Surgeries / Serious Illnesses:

_____ When _____
_____ When _____

FAMILY HISTORY: (Circle "NO" or "YES")			Family Member				Family Member
Heart Disease	NO	YES		Stroke	NO	YES	
Cancer	NO	YES		Diabetes	NO	YES	
Asthma	NO	YES		High Blood Pressure	NO	YES	
Arthritis	NO	YES		Thyroid Disease	NO	YES	
Anemia	NO	YES		AIDS	NO	YES	
Epilepsy	NO	YES		HIV+	NO	YES	
Hearing Loss	NO	YES		Hepatitis A, B, C	NO	YES	

PATIENT SOCIAL HISTORY:

Use of Alcohol: Moderate _____ Rarely _____ Never _____ Use of Tobacco: How Much? _____ Prev., but Quit on _____ Never _____

Use of Drugs: Type/Frequency _____ Never _____

Authorization To Release Medical Information & Assignment of Insurance Benefits

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim, I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services. I understand that I am responsible for (a) any amounts applied to the deductible, as well as the 20% Co-Insurance and any non-covered services under the Medicare Program; and (b) for charges not paid by my Insurance. This authorization in no way relieves me of the responsibility of making payment to South Florida Sinus and Allergy Center, Inc., and any other costs incurred in the process of securing payment in the event that they should not receive any payment from my insurance company.

DATE: _____ SIGNATURE (Patient or Parent/Guardian): _____