Ear, Nose & Throat Associates of New York, P.C.
Hear Better, Breathe Better, Feel Better
www.nyents.com

EXISTING PATIENT INTAKE FORM

Patient's Last Name _____ First Name_____ Middle Initial _____

Date of Birth_____ E-mail Address _____

Medical Doctor Name _____ Medical Doctor Telephone _____

Medical Doctor Fax_____ Medical Doctor Address _____

Language _____ Race _____ Ethnicity _____

Emergency Contact _____ Phone # _____

PHARMACY INFORMATION (Include Address &/or Phone**)**

_____

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Ear, Nose & Throat Associates of New York, P.C. to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal): ☐ No Current Medications

List of Medication(s)	Dosage	List of Medication(s)	Dosage	List of Medication(s)	Dosage
1._____	_____	4._____	_____	8._____	_____
2._____	_____	5._____	_____	9._____	_____
3._____	_____	7._____	_____	10._____	_____

ALLERGIES TO MEDICATIONS: ☐ No Allergies to Medications

_____

SMOKING STATUS & SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No ☐ Former Amount per day? _____ Quit Date? _____
Exposed to second hand smoke? ☐ Yes ☐ No
Alcohol Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____
Caffeine Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____

REVIEW OF SYSTEMS: Please mark where applicable

Ear problems

Yes	No	
☐	☐	Dizziness
☐	☐	Drainage
☐	☐	Ear pain
☐	☐	Exposure to Excessive Noise
☐	☐	Hearing loss
☐	☐	Infections
☐	☐	Itchiness
☐	☐	Ringing /Noise in Ear

Mouth & Throat problems

Yes	No	
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Sore Throat
☐	☐	Sores/Ulcers in Mouth

Nose & Sinus problems

Yes	No	
☐	☐	Congestion
☐	☐	Facial Pain
☐	☐	Mouth Breathing
☐	☐	Nose Bleeds
☐	☐	Post Nasal Drainage
☐	☐	Runny Nose
☐	☐	Sneezing

Patient Name: _____ **DOB:** _____

Responsible Party Signature: _____ **Date:** _____