ROCK[illegible]AIN EAR NOSE AND THROAT
PAT[illegible]T INFORMATION

Date: _____

Patient's Name; (last) _____ (first) _____ (mid initial)_____
Mailing address: _____
City: _____ Zip: _____
Phone numbers: Home: _____ Mobile: _____
Email: _____
Date of Birth (mm/dd/yyyy): __/__/____ . Age: _____ Sex: M/F SSN: _____
Marital Status: ❑Married ❑Single ❑Divorced ❑Other:
Patient Employer: _____ Work Phone: _____
Emergency Contact: _____ Phone: _____

GUARANTOR INFORMATION

Person responsible for payment: _____
Relationship to patient: _____

_____

INSURANCE INFORMATION

Primary Insurance Company: _____
Address:
City: _____ State: _____ Zip: _____

Insured's Name: _____ Member Number: _____

Group Number: _____

Secondary insurance (If any): _____

Primary Rx Insurance: _____

Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Specialty Pharmacy Name: _____

Phone #: _____ Fax #: _____

Primary Care Physician (PCP): _____ Referring Physician: _____

Have you previously been seen at our practice? Y/ N Date Last Seen: _____

VOICE MESSAGE CONSENT

If I am unable to be reached directly by phone, I authorize you to leave voice messages for me at the following.
number(s): Home: _____ Work: _____ Cell: _____ Other: _____
I give permission for Name: _____ To receive my information.

AUTHORIZATIONS AND PRIVACY PRACTICES

Payment and Release of Information: By signing below, thereby authorize payment to be made directly to my physician, for medical and/or surgical benefits, if any. A copy of this authorization shall be valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance. I hereby authorize ROCKY MOUNTAIN ENT GROUP to release information requested by my insurance company, I also authorize ROCKY MOUNTAIN ENT GROUP to release information to any hospital or physician I may be referred to by this office,

Notice of Privacy Practices: By signing below, I hereby acknowledge that I received a copy of the Notice of Privacy Practices,

SIGNATURE: _____ DATE: _____

ROCKY MOUNTAIN EAR, NOSE & THROAT
1501 WEST MINERAL AVEUNE, SUITE 270
LITTLETON, CO 80120
303-795-5587

OFFICE POLICYRocky Mountain ENT strives to provide our patients with the best care possible. In doing so, we will need you to provide our office with complete and accurate insurance information at the time of service in order to file insurance claims on your behalf. The following is a statement of our office policy; we require you to read, agree to, and sign to any non-emergent treatment.

All patients must complete our Patient Information Form prior to being seen by our physicians. This form must be updated every six months if you have moved, or changed insurance companies. If you have new insurance you must provide our office with a copy of your new insurance card.

It is the patients responsibility to provide current insurance info oration. If you do not bring your Insurance card or information to your appointment, you will be expected to pay for services upon check out. You may also, have the option to reschedule.

Referrals: If your insurance plan requires a referral from your Primary Care Physician, it is your responsibility to insure that the referral is current and our office has received the referral prior to your appointment. In the event our office does not either have a referral or a current referral you may choose to either reschedule your appointment or pay for the services in full upon check out.

Co-Payments: Co-Payments must be made upon check-in. Our office accepts Cash, Check, Master Card and Visa. Please note for all checks there will be a $25.00 returned fee plus bank charges.

No Insurance: Payment is due at the time of service.

Endoscopy/Laryngoscopy: In the event that your condition requires an endoscopy/laryngoscopy, a fiber optic scope may be utilized in office to further evaluate and treat your condition. Please be aware that the American Medical Association notes that this is a surgical procedure. **You may be responsible for any charges that exceed the maximum allowable amount your insurance will pay for this exam.**

I have read and fully understand, and agree to all terms set forth in the above Office Policy.

_____ Responsible Party (Please Print Name)

_____ Sign and Date

_____

Today's Date _____

Rocky Mountain ENT: Health History Form

Name_____ Age _____ Date of Birth_____

Primary Care Physician_____ Referring Physician_____

Preferred Pharmacy (address if known)_____

Height_____ Weight_____

MEDICAL HISTORY: Check all that apply

- ☐Abnormal bleeding /Hemophilia
- ☐Artificial Heart Valve
- ☐Acid Reflux/GERD
- ☐AIDS/HIV
- ☐Anemia/Sickle Cell
- ☐Arthritis
- ☐Asthma
- ☐Autoimmune Disorder
- ☐Breathing/Sleep Problems
- ☐Cancer
- ☐Cardiovascular Disease
- ☐Chemo/Radiation
- ☐Cold Sores/Fever Blisters
- ☐Diabetes
- ☐Dizziness
- ☐Emphysema (COPD)
- ☐Epilepsy/Seizures
- ☐Frequent Headaches
- ☐Glaucoma
- ☐Hearing loss
- ☐High Cholesterol
- ☐Joint Replacement
- ☐Kidney Problems
- ☐Liver Problems/Hepatitis
- ☐Migraines
- ☐Mental Health Disorder
- ☐Neurological Disorder
- ☐Organ Transplant
- ☐Osteoporosis
- ☐Seasonal Allergies
- ☐Stroke
- ☐Tinnitus
- ☐Thyroid Problems
- ☐Tuberculosis
- ☐Ulcers
- ☐Vertigo
- ☐Congenital Heart Defect
- ☐Congestive Heart Failure
- ☐Coronary Heart Disease
- ☐Heart Attack
- ☐Heart Murmur
- ☐High/ Low Blood Pressure
- ☐Pacemaker
- ☐Rheumatic Fever

☐Other: _____ _____

_____

SURGICAL HISTORY (Please provide date if known): ☐ Check if NONE

_____ _____ _____

_____ _____ _____

_____

ALLERGIES to medications: ☐ Check if NONE

_____ _____ _____

_____ _____ _____

_____

CURRENT MEDICATIONS: **Include** Prescriptions, over-the-counter meds, and vitamins/supplements

Please give dose if known

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please see reverse →

Aspirin?_____

Other blood thinners (Coumadin/warfarin, Plavix, Eliquis, Xarelto, Brilinta, etc.) _____

_____ _____ _____

_____

FAMILY HISTORY (medical illnesses and surgeries + relationship)

_____ _____

_____ _____

_____

SOCIAL HISTORY:

Cigarette use (circle one): Never smoker Former Smoker Current Smoker

If current or former smoker: _____#packs/day _____years

Vaping: NO YES If so, how much_____

Alcohol use (circle one): NO YES If so, # drinks per week_____

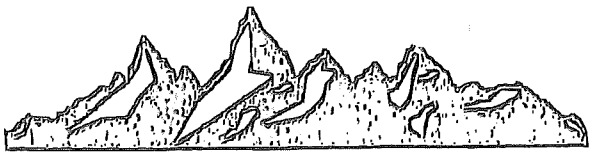
Marijuana use: NO YES If so, how much _____

Recreational drug use: NO YES If so, type_____ how often_____

Caffeine use: NO YES If so, how much_____

Please check any recent symptoms that you have been experiencing:

- ☐ EASY BRUISING
- ☐ HEARING LOSS
- ☐ RINGING/TINNITUS
- ☐ VERTIGO
- ☐ RECENT CHANGE IN VISION
- ☐ NASAL OBSTRUCTION
- ☐ NASAL BLEEDING
- ☐ NASAL FRACTURE IN PAST
- ☐ RECENT DENTAL WORK
- ☐ RADIATION EXPOSURE
- ☐ CANCER TREATMENTS
- ☐ TROUBLE SWALLOWING
- ☐ CHRONIC COUGH
- ☐ CHRONIC HOARSENESS
- ☐ SNORING
- ☐ PULMONARY PROBLEMS
- ☐ ARTHRITIS



Rocky Mc .. ' Nose and Throat

Sinus medications list

Name: _____

Date: _____

Please list or check any of the nasal or sinus medications you have recently taken:

Nasal Steroid Sprays

___Flonase
___Fluticasone
___Nasacort
___Nasonex
Other:
How long have you used these sprays? _____

Antihistamine Sprays

___Patanase
___Azalastine

___Saline nasal sprays

Saline Irrigations:

___Nielmed rinse
___Neti pot

Antibiotics you have taken in the last 12 months:

___Penecillin
___Amoxicillin
___Bactrim
___Tetracycline
___Clindamycin
___Zithromax
___Augmentin (Amox/Clavulante)
___Cephalexin
___Levaquin (Levofloxacin)
___Ciprofloxacin
___Avelox (Moxifloxacin)
Other:

Decongestants/Antihistamines

___Allegra
___Claritin
___Zyrtec
___Mucinex, Mucinex D
___Sudafed
___Afrin/Neosynephrine sprays