FITZPATRICK
Ear Nose & Throat Clinic, P.C.
Philip C. Fitzpatrick, MD
Elaine L. Fitzpatrick, MD
801 William Ave. • North Platte, NE 69101
308-532-3330

Account# _____ F/C _____

Resp.Party# _____ DR _____ LOC _____

I. PATIENT INFORMATION

Patient _____ (Last First Middle) Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____

Mailing Address _____ (City) _____ (State) _____ (Zip)

Hm.Ph. _____ Cell Ph. _____ Date of Birth _____ Sex M or F

Social Security# _____ Marital Status Married Single Widowed Divorced (circle one)

Employer _____ Student Full Part-time (circle one)

Referred by _____ Employment Status (circle one): Full-time, Part-time, Retired, Self Employed, Not Employed, Military Active, Unknown

Date of Injury _____ Is the injury work related? _____

Emergency Contact _____ Emergency Phone # _____

Mother's Full Name _____ Father's Full Name _____

II. RESPONSIBLE PARTY INFORMATION

Responsible Party _____ (Last First Middle) Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____

Mailing Address _____ (City) _____ (State) _____ (Zip)

Hm.Ph. _____ Wk.Ph. _____ Ext. _____ Date of Birth _____ Sex M or F

Social Security# _____ Employment Status (circle one): Full-time, Part-time, Retired, Self Employed, Not Employed, Military Active, Unknown

Employer _____

II. INSURANCE INFORMATION

ATTACH COPY OF CARD(S)

PRIMARY

Insurance Company _____

SECONDARY SUPPLEMENTAL

Insurance Company _____

V. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address _____ (City) _____ (State) _____ (Zip)

Hm.Ph. _____ Wk.Ph. _____ Ext. _____

Date of Birth _____ Sex M or F

Employer _____ Status _____

Address _____ (City) _____ (State) _____ (Zip)

Hm.Ph. _____ Wk.Ph. _____ Ext. _____

Date of Birth _____ Sex M or F

Employer _____ Status _____

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Dr Philip C. and/or Elaine L. Fitzpatrick, MD. I understand that I am responsible for all fees at time of service, regardless of insurance, including any legal or other costs incurred in the collection of this account, if it becomes delinquent.

Signature _____ Date _____

CHILD'S MEDICAL HISTORY FOR: _____

PAST MEDICAL HISTORY:

Prenatal:

During your pregnancy did you have:

High blood pressure?	Yes	No
High blood sugar?	Yes	No
Major illness?	Yes	No

If yes, explain: _____

_____

Neonatal:

Date of birth: _____

Birth weight: _____

Was your child premature (born prior to 36 weeks)?	Yes	No
Complications during labor or delivery?	Yes	No
Prolonged hospital stay?	Yes	No
Formula fed?	Yes	No
Breast fed?	Yes	No
Any medical problems during newborn period?	Yes	No

If yes, explain: _____

_____

Childhood:

Chickenpox?	Yes	No
Ear infections?	Yes	No
Sinus infections?	Yes	No
Pneumonia?	Yes	No
Urinary tract infections?	Yes	No
Asthma?	Yes	No
Hay fever?	Yes	No

Any hospitalizations? _____

_____

Past Surgical History:

_____

_____

_____

Environmental Exposures:

Daycare?	Yes	No
Cigarette smoke?	Yes	No
Drinking from bottle?	Yes	No

Immunizations up to date? Yes No

Medications:

_____

_____

_____

_____

_____

_____

Allergies to:

Antibiotics? Yes No

If yes, what? _____

Pain medication? Yes No

If yes, what? _____

Aspirin or ibuprofen?	Yes	No
Iodine/intravenous dye?	Yes	No
Food?	Yes	No

If yes, what? _____

Animals? Yes No

Other? _____

_____

Family History:

Any family members with chronic illness or congenital abnormalities? Yes No

If yes, what? _____

_____

Any family members with mental illness? Yes No

If yes, whom? _____

Social History:

Patient lives with: _____

Are the patient's parents: Married [ ] Unmarried [ ] Separated [ ] Divorced [ ] Widowed [ ]

Are you or your spouse a stepparent? Yes No

Is the child in custody of someone other than a parent or stepparent? Yes No

If yes, whom? _____

Siblings: # brother(s) _____ # sisters(s) _____

Level of education of patient: _____

Completed by: _____

Date: _____

Review of Systems

Name _____

Has your child currently or recently had any of the following?

General:

Good general health?	No	Yes
Abnormal weight gain?	No	Yes
Abnormal weight loss?	No	Yes

Eyes:

Infections?	No	Yes
Cross-eyed?	No	Yes
Vision problems?	No	Yes

Ears:

Infections:		
Right	No	Yes
Left	No	Yes
Drainage:		
Right	No	Yes
Left	No	Yes
Hearing loss:		
Right	No	Yes
Left	No	Yes

Nose:

Sinusitis?	No	Yes
Chronic runny nose?	No	Yes
Nasal obstruction?	No	Yes
Nose bleeds?	No	Yes

Throat:

Sore throat?	No	Yes
Hoarseness?	No	Yes
Bad breath?	No	Yes
Snoring?	No	Yes
Trouble sleeping & breathing at night?	No	Yes

Neck:

Enlarged lymph nodes?	No	Yes
Enlarged thyroid?	No	Yes
Other neck masses?	No	Yes

Cardiovascular:

Heart murmur?	No	Yes
Heart trouble?	No	Yes

Respiratory:

Chronic or frequent cough?	No	Yes
Shortness of breath?	No	Yes
Wheezing?	No	Yes

Gastrointestinal:

Diarrhea?	No	Yes
Constipation?	No	Yes
Nausea & vomiting?	No	Yes
Abdominal pain?	No	Yes
Acid reflux?	No	Yes

Genitourinary:

Urinary tract infections?	No	Yes

Musculoskeletal:

Swelling of joints?	No	Yes
Curvature of spine?	No	Yes

Integumentary:

Rash?	No	Yes
Abnormal birth marks?	No	Yes

Neurological:

Headaches?	No	Yes
Seizures?	No	Yes
Weakness of limbs?	No	Yes
Motor delay?	No	Yes
Speech delay?	No	Yes
Learning disability?	No	Yes
Attention deficit disorder?	No	Yes

Psychiatric:

Anxiety?	No	Yes
Depression?	No	Yes

Endocrine:

Diabetes?	No	Yes
Thryoid disorder?	No	Yes
Hormonal disorder?	No	Yes

Hematologic/Lymphatic:

Poor healing?	No	Yes
Bleeding tendency?	No	Yes
Easy bruising?	No	Yes
Anemia?	No	Yes
Past transfusions?	No	Yes
Enlarged lymph nodes?	No	Yes

Immunologic:

Immune deficiency?	No	Yes

Reviewed by _____ M.D.

NAME_____ DATE_____

ALLERGIES_____

CURRENT MEDICATIONS UPDATED_____

SURGERIES

Reviewed by_____M.D.

FITZPATRICK EAR, NOSE & THROAT CLINIC, P.C.

Patient Consent Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Signature of Patient or Responsible Party Date

Reason Patient is unable to sign (if applicable)_____

_____ _____

Fitzpatrick Ear, Nose & Throat Clinic, P.C. Staff/Witness Date