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	SECONDARY SUPPLEMENTAL
Insurance Company _____	Insurance Company _____

V. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address _____	Address _____
_____ (City / State / Zip)	_____ (City / State / Zip)
Hm.Ph. _____ Wk.Ph. _____ Ext. _____	Hm.Ph. _____ Wk.Ph. _____ Ext. _____
Date of Birth _____ Sex M or F	Date of Birth _____ Sex M or F
Employer _____ Status _____	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

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS

Are you currently having any of the following?

CONSTITUTIONAL

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

EYES

Blurred vision	No	Yes
Double vision	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

EARS

Hearing loss		
Right	No	Yes
Left	No	Yes
Ringing		
Right	No	Yes
Left	No	Yes
Infections		
Right	No	Yes
Left	No	Yes
Drainage		
Right	No	Yes
Left	No	Yes
Pain		
Right	No	Yes
Left	No	Yes

NOSE

Sinus pain/pressure	No	Yes
Runny nose/postnasal drainage	No	Yes
Nose bleeds	No	Yes
Nasal obstruction	No	Yes

THROAT

Sore throat	No	Yes
Trouble/painful swallowing	No	Yes
Hoarseness	No	Yes
Bad breath or taste	No	Yes
Snoring	No	Yes
Trouble sleeping/breathing at night	No	Yes

NECK

Swollen lymph nodes	No	Yes
Thyroid enlargement	No	Yes
Neck mass	No	Yes

CARDIOVASCULAR

Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Wheezing	No	Yes

GASTROINTESTINAL

Diarrhea	No	Yes
Nausea or vomiting	No	Yes
Heartburn or acid reflux	No	Yes
Peptic ulcer	No	Yes

GENITOURINARY

Burning or painful urination	No	Yes
Kidney stones	No	Yes

MUSCULOSKELETAL

Arthritis	No	Yes
Difficulty in walking	No	Yes
Recent injury	No	Yes

INTEGUMENTARY

Change in skin color	No	Yes
Change in size/shape of moles	No	Yes
Rash	No	Yes

NEUROLOGICAL

Dizziness	No	Yes
Seizures	No	Yes
Headaches	No	Yes
Numbness/weakness	No	Yes

PSYCHIATRIC

Anxiety	No	Yes
Depression	No	Yes

ENDOCRINE

Thyroid disease	No	Yes
Diabetes	No	Yes
Glandular or hormone problem	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding tendency	No	Yes
Anemia	No	Yes
Past transfusions	No	Yes
Swollen lymph nodes	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin or other adverse reaction to:
Antibiotics/pain medication/aspirin/iodine, etc?

No Yes

If yes, please list: _____

_____

_____

Known food allergies: _____

_____

_____

Reviewed by _____ M.D.

PATIENT NAME: _____ DATE: _____

Have YOU had any of the following? (If yes, what type?)			Has anyone in YOUR FAMILY? (If yes, who?)		
Diabetes _____	No	Yes	No	Yes	_____
Hypertension	No	Yes	No	Yes	_____
Cancer _____	No	Yes	No	Yes	_____
Stroke _____	No	Yes	No	Yes	_____
Heart trouble _____	No	Yes	No	Yes	_____
Arthritis	No	Yes	No	Yes	_____
Seizures _____	No	Yes	No	Yes	_____
Bleeding tendency _____	No	Yes	No	Yes	_____
Asthma	No	Yes	No	Yes	_____
Emphysema	No	Yes	No	Yes	_____
Sleep Apnea	No	Yes			
Hepatitis	No	Yes			
AIDS or Positive HIV	No	Yes			
Venereal disease _____	No	Yes			
Hereditary defects _____	No	Yes			

Previous Hospitalization: _____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Occupation: _____

Use of Alcohol: Never ____ Rarely ____ Moderate ___ Daily ____; If daily, ____ drinks/day

Use of Tobacco: Never ____ Previously smoked ___ pks/day x ____ years, but quit ____ years ago

Currently smoke _____ packs/day x ____ years

Chewing Tobacco: _____ cans/week x _____ years;

Use of Drugs: Never _____ Type/Frequency _____

Excessive exposure at home or work to: Fumes ____ Dust ____ Solvents ____ Air-borne particles ____ Noise ____

Level of Education _____

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