

PATIENT INFORMATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Sex:  Male  Female

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Information

Primary Insurance Provider: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_

Secondary Insurance Provider: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Subscriber Social Security #: \_\_\_\_\_

Primary Care Physician

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Information

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Authorization # (if needed): \_\_\_\_\_

Emergency Contact Information

Name and Relationship of Emergency Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please Read & Sign

I authorize the release of any medical or other information necessary to process claims for payment. I authorize payment of medical benefits to Camino Ear, Nose & Throat Clinic, James W. Linehan, M.D., Michael T. Murray, M.D., Hussein Samji, M.D. MPH, and/or Jennifer Tucker, Au.D.

I understand that payment is expected when services are rendered unless insurance coverage is in effect. A balance may remain after my insurance carrier has paid. I understand that this remaining balance is my financial responsibility.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Michael T. Murray, M.D.

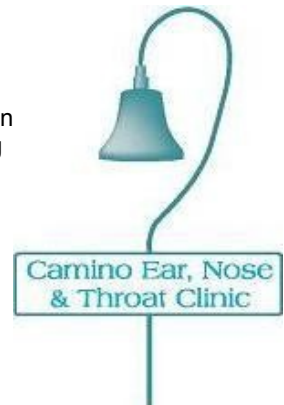
Jennifer Grady, M.D., MPH

James W. Linehan, M.D.

Hussein Samji, M.D., MPH

Jennifer Tucker, Au.D.

Nicole Conrad, Au.D.



## NOTICE OF PRIVACY PRACTICES

You have the right to see and receive a copy of your health information with a few exceptions. A written request must be submitted regarding the information you want to see. If you also want a copy of your records, we reserve the right to charge a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. You must submit a written request to make any changes. If you wish to include a statement in your file, please provide it in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health & Human Services, 200 Independence Ave., SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 408-227-6300.

This notice goes into effect as of April 14, 2003.

I acknowledge I have read and understand this notice.

Signed: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Date: \_\_\_\_\_



# Camino Ear, Nose & Throat Clinic

## PATIENT INFORMATION FORM

APPOINTMENT DATE: \_\_\_\_\_

Name: \_\_\_\_\_  

Last
First
Middle

### MEDICAL HISTORY

Are you taking any drugs, medications or vitamins?  Yes  No      If yes, list:  
 1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_

Are you allergic to any medications?  Yes  No      If yes, list:  
 1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?  Yes  No  
 If you had a bad reaction, describe: \_\_\_\_\_

Please list any illnesses in your family (for example: heart disease, diabetes, cancer, Alzheimer's, Parkinson's):  
 \_\_\_\_\_

Do you have now, or have ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
<b>Lungs:</b>			<b>Gastrointestinal:</b>		
Asthma or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest x-rays	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal/neurological:</b>		
<b>Cardiovascular:</b>			Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
History of leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other systemic:</b>	<b>YES</b>	<b>NO</b>
Abnormal electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hematologic/metabolic:</b>	<b>YES</b>	<b>NO</b>	Corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ear disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever had surgery?  Yes  No  
 If Yes, what kind of surgery and when?  
 \_\_\_\_\_  
 \_\_\_\_\_

# Camino Ear, Nose & Throat Clinic

List any other diseases or conditions not covered above: \_\_\_\_\_

**Social History:**

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per week

Do you smoke?  NO  YES  QUIT If YES, how much: \_\_\_\_\_

If you've QUIT, When did you quit and how long did you smoke? \_\_\_\_\_

Have you had or have you been exposed to HIV (AIDS)?  Yes  No

(Women) Are you pregnant?  Yes  No Due Date: \_\_\_\_\_

**SYMPTOMS** Check YES only for those symptoms you have developed.

<b>General:</b>	<b>YES</b>	<b>NO</b>	<b>Eye, Ear, Nose, Throat:</b>	<b>YES</b>	<b>NO</b>	<b>Muscle/Joint/Bone:</b>	<b>YES</b>	<b>NO</b>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Pain, weakness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin:</b>	<b>YES</b>	<b>NO</b>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal:</b>	<b>YES</b>	<b>NO</b>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Appetite poor	<input type="checkbox"/>	<input type="checkbox"/>	Vision – Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Change in moles	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Vision – Halos	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Bowel changes	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genito-Urinary:</b>	<b>YES</b>	<b>NO</b>	Scars	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Sore that won't heal	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological:</b>	<b>YES</b>	<b>NO</b>
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Lack of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Arm & leg weakness	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN Only:</b>	<b>YES</b>	<b>NO</b>	Trouble with balance	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Abn Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	Trouble talking	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Extreme menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>			
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>			
<b>MEN Only:</b>	<b>YES</b>	<b>NO</b>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>			
Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			
Erection difficulty	<input type="checkbox"/>	<input type="checkbox"/>						
Lump in testicles	<input type="checkbox"/>	<input type="checkbox"/>						
Penis discharge	<input type="checkbox"/>	<input type="checkbox"/>						
Sore on penis	<input type="checkbox"/>	<input type="checkbox"/>						
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>						