2032 Medical Park Drive, Newberry, SC 29108
Phone: (803) 630-5353 \ Fax (803) 630-5343
http:www.carolinapinesent.com

ADULT NEW PATIENT INTAKE FORM

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Gender (Circle one): Male Female Other

Street Address: _____

City: _____ County: _____ Zip: _____

Marital Status (Circle one): Married Single Separated Divorced

Name of Spouse: _____

Primary Phone Number: _____ Type: Cell Home Work

Secondary Phone Number: _____ Type: Cell Home Work

Primary Email Address: _____

Secondary Email Address: _____

Emergency Contact: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Medical Insurance Company: _____

Ins. Co. Address: _____

Ins. Co. Phone Number: _____ Patient's Policy #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Plan Name: _____ Policy Holder #: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Effective Date: _____ Co-pay Amount: _____ Deductible: _____

Secondary Medical Insurance Company: _____

Ins. Co. Address: _____

Ins. Co. Phone Number: _____ Patient's Policy #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Plan Name: _____ Policy Holder #: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Effective Date: _____ Co-pay Amount: _____ Deductible: _____

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for Visit Today: _____

Referring Physician: Referring Physician: _____

WHAT ARE YOUR PRESENT SYMPTOMS? (PLEASE CHECK ALL THAT APPLY)

- Ear infection
- Dizziness
- Recurring sore throat
- Swallowing difficulty
- Nasal blockage
- Enlarged glands
- Coughing up blood
- Other: _____
- Drainage from ears
- Hearing loss
- Strep throat
- Sore in mouth
- Sinus trouble
- Strange odor or taste
- Bleeding gums
- Other: _____
- Ringing in ears
- Vertigo
- Hoarseness
- Nosebleeds
- Hay fever/seasonal allergies
- Cough
- Growth and neck/throat
- Other: _____

WHAT OTHER MEDICAL PROBLEMS DO YOU/HAVE YOU HAD? (PLEASE CHECK ALL THAT APPLY)

- Stroke
- Nervous disorders
- TIA
- Heart attack
- High blood pressure
- Diabetes
- Asthma
- COPD
- Kidney failure
- Bleeding disorders
- Cancer
  What type: _____
- High cholesterol
- Problems with anesthesia
- Autoimmune disease
  What type: _____
- Other: _____

PLEASE LIST ALL OF YOUR PRIOR SURGERIES WITH DATES (USE BACK OF THE PAGE IF NECESSARY):

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Have you ever used tobacco products on a regular basis? Yes: _ No: ___

If you did in the past, when did you quit? _____

Do you use tobacco products currently? Yes: _____ No: ___

If yes do you? Smoke: ____ Use Smokeless Tobacco: _ How much per day? ____

Do you use alcohol? Yes: _ No: ___ If yes, how much alcohol do you use on a regular basis? _____

Do you currently use any illicit drugs including marijuana, cocaine, methamphetamine, heroin, or other street drugs? Yes: _____ No: ___

WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY? (PLEASE CHECK ALL THAT APPLY)

- Stroke
- Nervous disorders
- TIA
- Heart attack
- High blood pressure
- Diabetes
- Asthma
- COPD
- Kidney failure
- Bleeding disorders
- Cancer
  What type: _____
- High cholesterol
- Problems with anesthesia
- Autoimmune disease
  What type: _____
- Other: _____

Carolina Pines ENT

Wayne J. Harsha, MD

REVIEW OF SYSTEMS:

WHICH OF THE FOLLOWING HAVE YOU HAD IN THE LAST TWO WEEKS? (PLEASE CHECK ALL THAT APPLY)

Constitutional:

• Fevers • Chills • Night sweats • Unexplained weight loss

ENT:

• Hearing Changes • Ear pain • Nasal Congestion, • Sinus Pain, • Hoarseness, • Sore throat, • Runny Nose, •Swallowing Difficulty

Eyes:

• Eye Pain, • Swelling, • Redness, • Foreign Body, • Discharge, • Vision Changes

Cardiovascular:

• Chest Pain, • Shortness of breath, • Difficulty Breathing on Exertion, • Palpitations

Respiratory:

• Cough, • Sputum, • Wheezing, • Smoke Exposure, • Difficulty breathing

Gastrointestinal:

• Nausea, • Vomiting, • Diarrhea, • Constipation, • Pain, • Heartburn, • Jaundice

Genitourinary:

• Pain with urination, • Urinary Frequency, • Blood in the urine, • Urinary Incontinence, • Urgency

Musculoskeletal:

• Joint pain, • Muscle pain, • Joint Swelling, • Joint Stiffness, • Back Pain, • Neck Pain

Skin:

• Skin Lesions, • Itching • Hair Changes, • Breast/Skin Changes

Neuro:

• Weakness, • Numbness, • Loss of Consciousness, • Dizziness, • Headache

Psych:

• Anxiety/Panic, • Depression, • Insomnia, • Personality Changes,

Heme/Lymph:

• Bruising, • Bleeding, • Transfusions History, • Lymph node enlargement

Endocrine:

• Frequent urination, • Increased thirst, • Temperature Intolerance

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS (INCLUDING OTC AND HERBALS) (USE BACK IF NECESSARY):

_____ _____ _____

_____ _____ _____

WHAT ARE YOUR DRUG/MEDICATION ALLERGIES?

• Penicillin • Sulfa • NSAIDS • Morphine • Aspirin • Others: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Carolina Pines ENT & Allergy Associates notice of privacy practice.**

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