



EAR, NOSE & THROAT  
FACIAL PLASTIC SURGERY

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Diplomates American Board  
of Otolaryngology—  
Head & Neck Surgery

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Dear Patient,

For your convenience we have placed our new patient forms on our website:  
[www.bergerhenryent.com](http://www.bergerhenryent.com).

Please print and complete both forms using a blue or black pen. These forms will not become valid until the day of your appointment, so please do not date them.

When you arrive for your visit, please have your completed forms with you. Your copay may be paid by cash, check, credit card or money order.

It will be our pleasure to participate in your care and we look forward to meeting you!

Thank you!

*The Staff of Berger/Henry ENT*



**PATIENT INFORMATION SHEET**  
**(PLEASE PRINT & FILL OUT BOTH SIDES COMPLETELY)**



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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

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

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

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

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Social Security # \_\_\_\_\_

Sex:  Male  Female

Marital Status: \_\_\_\_\_

Are you currently employed?  Yes  No

Spouse's Profession: \_\_\_\_\_

Is your spouse currently employed?  Yes  No

Spouse's Employer: \_\_\_\_\_

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

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

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Profession: \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

**PERSON TO NOTIFY IN CASE OF EMERGENCY:**

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

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Patient's Pharmacy: \_\_\_\_\_

Pharmacy Phone: (\_\_\_\_\_) \_\_\_\_\_

Are you allergic to any medication, latex or adhesive tape? Please specify: \_\_\_\_\_

**INSURANCE INFORMATION:**

**PRIMARY** (Your) "MEDICAL" Insurance Company: \_\_\_\_\_

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

Insured  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

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

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

Social Security # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**SECONDARY** (Spouse or Other) Insurance Company: \_\_\_\_\_

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

Insured  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

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

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

Social Security # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Is this a  Workman's Comp or  Auto-related injury?**

**Date of injury:** \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

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

Insured  
Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_

### **ACCOUNT PAYMENT POLICY**

I understand all charges incurred by \_\_\_\_\_ are my responsibility. Any balance remaining after my primary insurance payment will be my responsibility. Any balances billed to my major medical carrier will be paid by me in full immediately upon receipt of my insurance check.

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AUTHORIZED SIGNATURE

### **MEDICARE AUTHORIZATION**

I request that payment under the medical/surgical insurance program be made to Alan S. Berger, M.D. on any bills for services rendered to \_\_\_\_\_, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed to process this claim or related Medicare claims. This authorization is further to apply to all private insurance claims that I may happen to use.

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AUTHORIZED SIGNATURE

### **TREATMENT AUTHORIZATION**

I hereby authorize any necessary procedures to be performed for the proper evaluation and management of my condition.

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AUTHORIZED SIGNATURE

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

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

Reason for visit (be specific): \_\_\_\_\_

When did complaint start? \_\_\_\_\_ Accident?  Yes  No

Brief History: \_\_\_\_\_

Were studies done?  Yes  No If yes, where? \_\_\_\_\_

What studies were done?  X-Ray  CT Scan  MRI  
 Other: \_\_\_\_\_

**REVIEW OF SYSTEMS (Recent Health Problems)**

- |   |   |   |
|---|---|---|
| <input type="radio"/> Hoarseness            | <input type="radio"/> Recurrent Head Cold | <input type="radio"/> Nausea                |
| <input type="radio"/> Difficulty Swallowing | <input type="radio"/> Sinus Trouble       | <input type="radio"/> Multiple Joint Pain   |
| <input type="radio"/> Enlarged Glands       | <input type="radio"/> Nasal Odors         | <input type="radio"/> Multiple Muscle Aches |
| <input type="radio"/> Sore Throats          | <input type="radio"/> Burning Eyes        | <input type="radio"/> Frequent Urination    |
| <input type="radio"/> Coughing up Blood     | <input type="radio"/> Headaches, Frequent | <input type="radio"/> Sweats/Chills         |
| <input type="radio"/> Blurred Vision        | <input type="radio"/> Strange Taste       | <input type="radio"/> Rashes                |
| <input type="radio"/> Ear Aches             | <input type="radio"/> Loss of Taste       | <input type="radio"/> Depression            |
| <input type="radio"/> Ear Discharge         | <input type="radio"/> Weight Loss         | <input type="radio"/> Anxiety               |
| <input type="radio"/> Ringing in Ears       | <input type="radio"/> Dizziness           | <input type="radio"/> Unsteady Gait         |
| <input type="radio"/> Decreased Hearing     | <input type="radio"/> Shortness of Breath |   |
| <input type="radio"/> Recurrent Nosebleeds  | <input type="radio"/> Cough-Chronic       |   |

Do you use tobacco or alcohol?  Yes  No Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**MEDICAL HISTORY - Check (X) where appropriate**

- | YOU                   | RELATIVE              |                      | YOU                   | RELATIVE              |                  |
|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|------------------|
| <input type="radio"/> | <input type="radio"/> | Diabetes Mellitus    | <input type="radio"/> | <input type="radio"/> | Reflux: _____    |
| <input type="radio"/> | <input type="radio"/> | Insulin              | <input type="radio"/> | <input type="radio"/> | Hiatal Hernia    |
| <input type="radio"/> | <input type="radio"/> | Pills                | <input type="radio"/> | <input type="radio"/> | Glaucoma         |
| <input type="radio"/> | <input type="radio"/> | High Blood Pressure  | <input type="radio"/> | <input type="radio"/> | Seizures         |
| <input type="radio"/> | <input type="radio"/> | Heart Disease/Attack | <input type="radio"/> | <input type="radio"/> | AIDS/HIV         |
| <input type="radio"/> | <input type="radio"/> | Heart Failure/Valve  | <input type="radio"/> | <input type="radio"/> | Liver Problems   |
| <input type="radio"/> | <input type="radio"/> | Heart Angina/Other   | <input type="radio"/> | <input type="radio"/> | Hepatitis        |
| <input type="radio"/> | <input type="radio"/> | Cancer: type         | <input type="radio"/> | <input type="radio"/> | Cirrhosis        |
| <input type="radio"/> | <input type="radio"/> | 1: _____             | <input type="radio"/> | <input type="radio"/> | Arthritis        |
| <input type="radio"/> | <input type="radio"/> | 2: _____             | <input type="radio"/> | <input type="radio"/> | Sarcoidosis      |
| <input type="radio"/> | <input type="radio"/> | Lung Disease         | <input type="radio"/> | <input type="radio"/> | Lupus            |
| <input type="radio"/> | <input type="radio"/> | Emphysema            | <input type="radio"/> | <input type="radio"/> | Gout             |
| <input type="radio"/> | <input type="radio"/> | Asthma               | <input type="radio"/> | <input type="radio"/> | Thyroid Problems |
| <input type="radio"/> | <input type="radio"/> | Other: _____         | <input type="radio"/> | <input type="radio"/> | Overactive       |
| <input type="radio"/> | <input type="radio"/> | Clotting Problems    | <input type="radio"/> | <input type="radio"/> | Underactive      |
| <input type="radio"/> | <input type="radio"/> | Neuromuscular        | <input type="radio"/> | <input type="radio"/> | Phlebitis        |
| <input type="radio"/> | <input type="radio"/> | MS                   | <input type="radio"/> | <input type="radio"/> | Other: _____     |

**MEDICATIONS:** Please list ALL current medications: \_\_\_\_\_

**ALLERGIES:** List: \_\_\_\_\_

**SURGERY:** List date and procedure: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Did he/she refer you?  Yes If no, referred by: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sports: List  (S/C) Serious/Competitive  (O) Occasional  (R) Rarely

**This Section For Subsequent Visits Only**

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

Reason for visit: \_\_\_\_\_

Changes to Health Status? \_\_\_\_\_

Meds? \_\_\_\_\_

Hospital? \_\_\_\_\_

Signature: \_\_\_\_\_

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

Reason for visit: \_\_\_\_\_

Changes to Health Status? \_\_\_\_\_

Meds? \_\_\_\_\_

Hospital? \_\_\_\_\_

Signature: \_\_\_\_\_

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

Reason for visit: \_\_\_\_\_

Changes to Health Status? \_\_\_\_\_

Meds? \_\_\_\_\_

Hospital? \_\_\_\_\_

Signature: \_\_\_\_\_

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

Reason for visit: \_\_\_\_\_

Changes to Health Status? \_\_\_\_\_

Meds? \_\_\_\_\_

Hospital? \_\_\_\_\_

Signature: \_\_\_\_\_