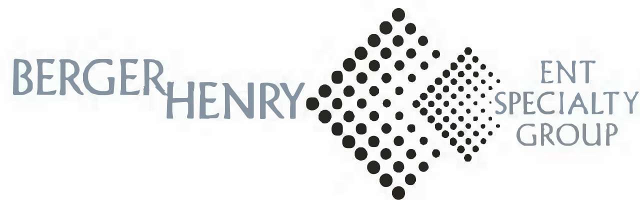

EAR, NOSE & THROAT
FACIAL PLASTIC SURGERY

ALAN S. BERGER, M.D.*
TODD C. MOREHOUSE, D.O.**
MARTA T. BECKER, M.D.
DONALD M. SESSO, D.O.**
LANA B. PATITUCCI, D.O.

BERGERHENRYENT.COM

BergerHenry ENT Center
60 West Germantown Pike
East Norriton, PA 19401
610.279.7878

Jamestown Medical Building
525 Jamestown Ave, Suite 104
Philadelphia, PA 19128
215.482.3100

Chestnut Hill Medical Building
8815 Germantown Ave, Suite 32
Philadelphia, PA 19118
215.248.2400

Regency Towers
1001 Easton Rd, Suite 106
Willow Grove, PA 19090
215.830.8620

Montella Crossing
108 Cowpath Rd, Suite 2
Lansdale, PA 19446
215.362.6700

400 Cresson Road
Suite 305
Oaks, PA 19456
484.392.7230

Diplomates American Board
of Otolaryngology–
Head & Neck Surgery

*Fellow of the
American College of Surgeons

**Fellow of the American Osteopathic
College of Otolaryngology

Dear Patient,

For your convenience we have placed our new patient forms on our website: 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 BergerHenry ENT

Please bring a detailed list of all medications:
(we have included a medication list for your convenience)
Include all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements. Including medication name, dosage, frequency and how it is taken.

Also include any and all allergies or not.

************Do not write your information on this page**************

PATIENT INFORMATION SHEET]
(PLEASE PRINT FILL OUT COMPLETELY)

Date____________________________

Primary Phone#:_________________________________H □ C □ W □

Name:____

Secondary Phone #______________________________H □ C □ W □

Address____

Age__________________ Date of Birth: ______/______/_______

City _________________________ State__________Zip________

Sex: Male □ Female □ Social Security ________________________________

EMAIL ADDRESS ____

Race:______________Ethnicity (Hispanic?/Not Hispanic?)________________

Primary Language___________________________

Pharmacy Information

Preferred Pharmacy Name____________________________

Address/Street/City____

Phone____

Secondary Pharmacy Name____________________________

Address/Street/City____

Phone____

REFERRING DOCTOR

Name_____________________________________Phone_______________

PRIMARY CARE PHYSICIAN

Name_____________________________________Phone_______________

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY. Please (√) with Whom we can share your Medical Information (HIPAA)?

Name_________________________________Relationship___________________Home/Cell Phone (____)_______________________HIPAA? □

Name_________________________________Relationship___________________Home/Cell Phone (____)_______________________HIPAA? □

Name_________________________________Relationship___________________Home/Cell Phone (____)_______________________HIPAA? □

MEDICAL INSURANCE INFORMATION ***Please bring your health insurance cards and photo ID***

PRI MARY (Insurance Company):____

Policy Number:_______________________________________ Group Number:_____________________________

Policy Holder/Subscriber Name___________________________ Date of Birth______/______/______ Relationship______________________

SECONDARY (Insurance Company____

Policy Number:_______________________________________ Group Number:_____________________________

Policy Holder/Subscriber Name___________________________ Date of Birth______/______/______ Relationship______________________

Is this a □ Workman's Comp or □ Motor Vehicle Injury? *(All below informaion must be completed prior to seeing the doctor.)*

Date of Injury:_____/_____/_____ Claim Number______________________________Patient Name__________________________________

Insurance Carrier:____________________________________ Address____

City:_______________________________ State_____________________Zip________________________

Insured's Name____ Date of Birth_____/_____/_____ Relationship_______________________

If Workman Comp, Employer's Name and Address____

Date: ___________________ **Patient Name:** ______________________________

Reason for visit: (*Please be specific*) ____
When did complaint start? ____
Accident? □Yes □No If yes, please provide a brief summary____
____
Were studies done? □ Yes □ No If yes, when and where? ____
What studies were done? □ X-ray □ CT scan □ MRI □ Sleep □ other ____
When and where? ____

Recent Health Problems (Review of Systems) √ All that Apply

□ Hoarseness
□ Rashes
□ Shortness of Breath
□ Blurred Vision
□ Coughing up Blood
□ Weight Loss
□ Nasal Odors
□ Decreased Hearing
□ Recurrent Head Cold
□ Cough-Chronic
□ Sweats/Chills
□ Sore Throats
□ Anxiety
□ Sinus Trouble
□ Ringing in Ears
□ Depression
□ Multiple Joint Pain
□ Headaches, Frequent
□ Enlarged Glands
□ Dizziness
□ Frequent Urination
□ Ear Discharge
□ Strange Taste
□ Recurrent Nosebleeds
□ Nausea
□ Difficulty Swallowing
□ Unsteady Gait
□ Burning Eyes
□ Ear Aches
□ Loss of Taste
□ Multiple Muscle Aches
□ Breastfeeding
□ Pregnancy? Expected Date_______ _____

	Self	Mother	Father	Sister	Brother	Daughter	Son
Diabetes Mellitus	□	□	□	□	□	□	□
Type 1 – Insulin Dependent	□	□	□	□	□	□	□
Type 2 – Non Insulin	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□
Heart Attack	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
Stents	□	□	□	□	□	□	□
Cancer **(Type)**	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□
Emphysema	□	□	□	□	□	□	□
Other Lung Disease	□	□	□	□	□	□	□
Neuromuscular	□	□	□	□	□	□	□
MS	□	□	□	□	□	□	□
Reflux	□	□	□	□	□	□	□
Hernia **(Type)**	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□
Seizures	□	□	□	□	□	□	□
Aids/HIV	□	□	□	□	□	□	□
Clotting Problems	□	□	□	□	□	□	□
Hepatitis	□	□	□	□	□	□	□
Cirrhosis	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□
Sarcoidosis	□	□	□	□	□	□	□
Lupus	□	□	□	□	□	□	□
Gout	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□
Thyroid Problems: **Overactive**	□	□	□	□	□	□	□
Underactive	□	□	□	□	□	□	□
Other Health Problem:	□	□	□	□	□	□	□

Do you use tobacco? □ Yes □ No Quit/how long? ______ □Never If yes, number of packs per day? ___ Number of years smoked? ________
Do you use alcohol? □ Never □ Occasionally □ Daily How much?________________________________
Please list any and all allergies: ex. Food? Seasonal? Pet? ____
____
Please list any past surgeries (Date and Procedure):____
____

Medication List

Patient Name____________________

Name of Medication	Dosage	Frequency	How is it taken

Include all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements.

☐ **I give consent to retrieve and use my medication history from SureScripts.**

Do you have any allergies to medication or other: If yes, please list:

____