BERGER HENRY ENT SPECIALTY GROUP | ALIGN ENT+ Allergy Partner

Patient Information

Name _____ DOB _____ Age_____Sex____

Address _____

Cell Phone_____Home Phone_____Email_____

Primary Language _____Race_____Ethnicity_____

Referring Doctor _____Referring Doctor Phone_____

Primary Doctor _____Primary Doctor Phone_____

Primary Pharmacy_____Primary Pharmacy Phone_____

Secondary Pharmacy_____Secondary Pharmacy Phone_____

Mail Order Pharmacy_____Mail Order Pharmacy Phone_____

Medical Insurance Information
Please bring your health insurance cards and photo ID to your appointment

Primary Insurance Company_____

Policy Number_____Group Number_____

Policy Holder/Subscriber Name_____

Policy Holder/Subscriber Date of Birth_____Relationship to Policy Holder_____

Secondary Insurance Company_____

Policy Number_____Group Number_____

Policy Holder/Subcriber Name_____

Policy Holder/Subcriber Date of Birth_____Relationship to Policy Holder_____

Is this a ☐ Workers' Comp or ☐ Motor Vehicle Accident Injury?

Date of Injury_____Group Number_____

Patient's Name_____Insurance Carrier_____

Insured Name_____Date of Birth_____Relationship_____

Adjustor Name _____Adjustor Phone_____

Insurance Address_____

If Workers' Comp, Employer Name_____

Employer's Address_____

_____REVIEWED BY STAFF

Reason for Visit (*Please be specific)*_____

_____

When did the complaint start?_____

Accident? ☐ No ☐ Yes

If yes, please provide a summary_____

Were studies done? ☐ No ☐ Yes

If yes, what studies were done? ☐ X-ray ☐ CT scan ☐ MRI ☐ Sleep ☐ Other_____

If yes, note when and where_____

Allergies

Do you have any medication allergies? ☐ No ☐ Yes

If yes, please list all medication allergies_____

_____

Please list all other allergies (e.g., food, seasonal, animals, latex)_____

_____

Current Medications

If you are not taking any prescription medications, please check this box ☐

List all prescription medications you are taking. If you need more room, please list them on a separate sheet and bring to your appointment.

Medication Name	Dosage	Frequency	How it is taken

Personal and Family Health History

Check the appropriate boxes if you or any family members have any of the following medical problems.

Medical Problem	Self	Mother	Father	Sister	Brother	Daughter	Son	None
Diabetes Mellitus Type 1 Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus Type 2 Non-Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐	☐
Overactive Thyroid	☐	☐	☐	☐	☐	☐	☐	☐
Underactive Thyroid	☐	☐	☐	☐	☐	☐	☐	☐
Other- Please list								

Social History

Current Tobacco User ☐ No ☐ Yes If yes, how many per day_____per week_____

Former Tobacco User ☐ No ☐ Yes If yes, how long?_____

Alcohol Consumption ☐ Never ☐ Occasionally ☐ Daily How much?_____

Surgical History

Please list date and procedure for any surgeries_____

_____