AUSTIN EAR CLINIC

New Patient Information

If hand writing, PLEASE PRINT

Name: ______________________________ **Date:** ______________
FIRST MIDDLE LAST

Address (street): ______________________________ **City**: ______________

State: __________ **Zip**: __________ **MALE** ☐ / **FEMALE** ☐ **Patient S.S. #** ______________

Date of Birth: __________ **Age**: ________ **E-mail Address**: ______________________

Home Phone: (____) __________ **Work Phone**: (____) __________ **Cell Phone**: (____) __________

Marital Status: S☐ M☐ D☐ W☐ **Primary Care Physician**: ______________________

Referring Doctor: ______________________ **Occupation**: ______________________

Employer: ______________________ **Employer Phone**: ______________________

Emergency Contact: ______________ **Contact Phone**: (____) __________ **Relationship**: __________

<u>PRIMARY</u> Insurance: ______________________ **Policy Holder Name**: ______________________

Relation to Patient: ______________ **Date of Birth**: ____________ **Policy Holder SS #** ______________

Policy I.D. Number: ______________________ **Group Number**: ______________________

<u>SECONDARY</u> Insurance: ______________________ **Policy Holder Name**: ______________________

Relation to Patient: ______________ **Date of Birth**: ____________ **Policy Holder SS #** ______________

Policy I.D. Number: ______________________ **Group Number**: ______________________

<u>PLEASE fill out this section for MINOR PATIENTS</u>

Mother: ______________________ **Mother's Date of Birth**: ______________ **S.S. #** ______________

Address (street): ______________________ **City**: __________ **State**: ______ **Zip**: ________

Employer: ______________________ **Occupation**: ______________________

Home Phone: (____) __________ **Employer Phone**: (____) __________ **Cell Phone**: (____) __________

Father: ______________________ **Father's Date of Birth**: ______________ **S.S. #** ______________

Address (street): ______________________ **City**: __________ **State**: ______ **Zip**: ________

Employer: ______________________ **Occupation**: ______________________

Home Phone: (____) __________ **Employer Phone**: (____) __________ **Cell Phone**: (____) __________

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Please check any of the following that apply to you.

- ☐ Sudden Hearing Loss
- ☐ Gradual Hearing Loss
- ☐ Allergy Symptoms
- ☐ Noise in Your Head
- ☐ Vertigo (spinning feeling)
- ☐ Dizziness
- ☐ Stopped-up Ears
- ☐ Ear Infections
- ☐ Ringing in Your Ears
- ☐ Noise Exposure
- ☐ Balance Problems
- ☐ Draining Ears
- ☐ Nose or Sinus Problems
- ☐ Pulsating Noise in Head
- ☐ Trouble Breathing through nose
- ☐ Ear Pain
- ☐ Trouble Understanding
- ☐ Throat Problems
- ☐ Hearing Aids
- ☐ Cochlear Implant(s)

Briefly state the reason for your initial visit with us.

____

____

Any ear/nose/throat/neck surgeries? ☐Yes ☐No **Have you had complications from anesthesia?** ☐Yes ☐No

Antibiotics: In the last 3 months, have you been on any treatment of antibiotics? ☐ Yes ☐ No

If YES, please list antibiotics taken: ____

PAST SURGERIES: Please list your past surgeries and the date of surgery.

Surgery: Date:	Surgery: Date:	Surgery: Date:

MEDICAL HISTORY: (Examples: Hospitalizations, diseases, medical conditions, traumatic injuries.)

Diagnosis: Date:	Diagnosis: Date:	Diagnosis: Date:

MEDICATIONS: Please list medications you are currently taking, and their dosages.

Medication: Dose :	Medication: Dose:	Medication: Dose:

Family History – Please check all that apply to you.

- ☐ Heart disease
- ☐ Hearing loss
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Cancer
- ☐ Arthritis
- ☐ Strokes
- ☐ Aneurysms
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Gout

Do you smoke? ☐Yes ☐No If YES, how much per day? ______________________

Do you consume alcohol? ☐Yes ☐No If YES, how much per day? ______________________

If you are female, is there a chance you might be pregnant? ☐Yes ☐No

Authorized signature: I authorize the release of any of my medical information/records necessary to process an insurance claim. I authorize payment of medical benefits to the Austin Ear Clinic and/or Dr. Patrick W. Slater.

______________________________________ ______________________

Patient Signature (for minor patients, signature of parent/guardian) **DATE**