

INSURANCE INFORMATION

Please attach a copy of/ or bring insurance card(s), authorization forms and picture I.D.

MEDICARE EFFECTIVE
NUMBER: _____ A only _____ B only _____ A&B _____ DATE: _____

PRIMARY CARE PROVIDER: _____ TPL NUMBER: _____

IDPA CASE #: _____ IDPA RIN ID: _____

PRIMARY INSURANCE: _____ TEL#: _____

CLAIM FILING ADDRESS: _____ CITY, STATE, ZIP: _____

POLICY#: _____ GROUP#: _____ EFF. DATE: _____

HOLDER NAME: _____ SS#: _____ CO-PAY: \$ _____

EMPLOYER NAME: _____ TEL. #: _____

RELATIONSHIP TO PATIENT _____ NOTATIONS: _____

SECONDARY INSURANCE: _____ TEL. #: _____

CLAIM FILING ADDRESS: _____ CITY, STATE, ZIP: _____

POLICY#: _____ GROUP#: _____ EFF. DATE: _____

HOLDER NAME: _____ SS#: _____ CO-PAY: \$ _____

EMPLOYER NAME: _____ TEL. #: _____

RELATIONSHIP TO PATIENT _____ NOTATIONS: _____

I have read and understand the payment and billing policies given to me. I understand that I am financially responsible for charges not paid by my medical insurance. I authorize any holder of medical information about me to release to any responsible health carrier and/or the Social Security Administration or its intermediaries, any information for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the Dept. of Oto-HNS for bills or services furnished to me during the period _____ to _____

Print Patient Name/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____

Date: _____

UNIVERSITY OF ILLINOIS
DEPARTMENT OF OTOLARYNGOLOGY-HEAD & NECK SURGERY
PATIENT MEDICAL HISTORY & PHYSICAL FORM

Patient Name: _____ Birthdate: _____ Age: _____

Sex: _____ Height: _____ Weight: _____ lbs. Occupation: _____

Chief Complaint:

Reason for Today's Visit: _____

Any recent tests done for above problem(s)? Please List: _____

Past History:

Please list any prior major illnesses and/or injuries: _____

Surgeries/ Hospitalization	Year	Complications:

Have you had previous plastic surgery? _____ What type? _____

Were you satisfied with the results? _____ How long have you considered having plastic surgery? _____

Have you ever had problems with anesthesia? YES NO

If yes, what were the complications? _____

Current Medication(s) including Aspirin, Diet Pills, and Herbal Supplements	Dose	Frequency

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIALS:

Family History:

Do you have a family history of trouble with anesthesia? YES NO

Do you have a family history of easy bleeding? YES NO

Social History:

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

No, I have never smoked No, I quit _____ years ago. I smoked _____ packs of cigarettes per day for _____ years.

Do you chew tobacco? Yes, I have chewed tobacco for _____ years. How much do you chew? _____

No, I have never chewed tobacco. No, I quit _____ years ago. I chewed _____ per day for _____ years.

Do you drink alcohol? No, never (or rarely) No, but I used to

Yes Daily One or more times a week One or more times a month

Review of Systems

Are you currently, or have you had, problems with:

Constitutional

Weight Gain Yes No
Weight Loss Yes No
Night Sweats Yes No
Insomnia Yes No

Circle One

Neurological

Numbness Yes No
Dizziness Yes No
Stroke Yes No
Headaches Yes No

Circle one

Eyes

Double Vision Yes No
Visual Loss Yes No

Psychiatric

Depression Yes No

Ear, Nose, Throat and Mouth

Hearing loss Yes No
Noise/ringing in ears Yes No
Drainage from the ear Yes No
Right side ___ Left Side ___ Both ___
Vertigo, Imbalance or dizziness Yes No
Fullness or pressure in ear Yes No
Right side ___ Left Side ___ Both ___
Nasal Congestion Yes No
Nasal Drainage Yes No
Difficulty breathing through the nose Yes No
Nose bleeds Yes No
Frequent Sinus infections Yes No
Frequent sore throat Yes No
Trouble swallowing Yes No
Hoarseness Yes No
Choking or Coughing Yes No
Throat clearing or gagging Yes No
Frequent cough Yes No

Allergic/Immunologic

Sneezing Yes No
Itchy eyes/nose Yes No
Itchy throat Yes No
Skin rash Yes No
HIV/AIDS Yes No

Respiratory

Asthma Yes No
Cough up blood Yes No
TB Yes No
Pneumonia Yes No
Trouble breathing at night Yes No
Snoring Yes No

Gastrointestinal

Bladder trouble Yes No
Kidney disease Yes No
Arthritis Yes No

Cardiovascular

Chest pain or angina Yes No
Heart trouble Yes No
Heart murmur Yes No
High blood pressure Yes No

Endocrine

Diabetes Yes No
Thyroid disease Yes No

Hematologic

Bleeding disorders Yes No
Easy bleeding Yes No

The above information is as accurate to the best of my knowledge

Patient Signature

Date

I have reviewed the above information with the patient.

Physician Signature

Date