BRANDON AREA EAR, NOSE & THROAT, P.A.
STEPHEN YAVELOW, M.D., F.A.C.S. BOARD CERTIFIED

PLEASE PRINT CLEARLY

PATIENT NAME _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMAIL _____
SOCIAL SECURITY _____
DATE OF BIRTH _____ AGE _____ SEX _____
MARITAL STATUS _____ SPOUSE _____
PHONE (H) _____ (C) _____
RESPONSIBLE PARTY _____
EMPLOYER _____ PHONE _____
ADDRESS _____
INSURED'S ADDRESS _____
CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR
PLEASE FILL IN BELOW

FATHER'S NAME _____
DATE OF BIRTH _____
SOCIAL SECURITY _____
EMPLOYER _____
ADDRESS _____
PHONE _____
MOTHER'S NAME _____
DATE OF BIRTH _____
SOCIAL SECURITY _____
EMPLOYER _____
ADDRESS _____
PHONE _____
MINOR CHILD LIVES WITH _____

PREFERRED METHOD OF CONTACT: HOME PHONE / CELL PHONE / WORK PHONE

WHO REFERRED YOU TO THIS OFFICE? _____
PRIMARY CARE PHYSICIAN _____ PHONE _____
PHARMACY NAME _____ PHONE _____

ETHNICITY: HISPANIC / LATINO NON-HISPANIC / NO-LATINO UNKNOWN / OTHER

RACE: AMERICAN INDIAN / ALASKA NATIVE NATIVE HAWAIIAN / PACIFIC ISLANDER ASIAN
BLACK / AFRICAN AMERICAN MULTI-RACIAL WHITE OTHER

1) PRIMARY INSURANCE

MEDICAL INS CO _____ POLICY # _____ GROUP # _____
ADDRES _____ CITY _____ STATE _____ ZIP _____
INS CO PHONE NUMBER _____
POLICY HOLDER'S NAME _____ DOB _____ SS# _____

2) SECONDARY INSURANCE

MEDICAL INS CO _____ POLICY # _____ GROUP # _____
ADDRES _____ CITY _____ STATE _____ ZIP _____
INS CO PHONE NUMBER _____
POLICY HOLDER'S NAME _____ DOB _____ SS# _____

MEDICAL HISTORY

	DIAGNOSIS	WHEN	HOSPITAL	M.D.
PREVIOUS OPERATIONS				
PREVIOUS HOSPITALIZATIONS				

DISEASES:	YES		NO	ADDT'L INFO
Heart Disease				
Lung Disease				
Asthma				
Diabetes				
High Blood Pressure				
Bleeding Disorder				
Liver Disease				
Jaundice or Hepatitis				

Height _____ **Weight** _____

PRESENT MEDICATIONS (including sprays, eye drops, as well as over the counter medicines)? _____

_____

What medications are you allergic to? _____

Are you allergic to pollens, molds, foods, etc? _____

Have you ever been allergy tested? YES / NO If yes, when & where? _____

Have you ever had a sleep study performed? YES / NO If yes, when & where? _____

Do you smoke? YES / NO CHOOSE ONE:

Current everyday smoker	
Current some days smoker	
Former Smoker	
Never Smoked	
Smoker, current status unknown	
Unknown if ever smoked	

Do you consume alcohol? YES / NO If so, how often? _____

Are there any diseases that tend to run in your family? If so, what and who has these problems?

_____

_____

Do you yourself have any chronic medical problems? _____

BRANDON AREA EAR, NOSE & THROAT, P.A.
STEPHEN YAVELOW, M.D., F.A.C.S.

PATIENT NAME _____ DOB _____

I, the undersigned, for myself or on behalf of the aforementioned patient, hereby authorize Dr. Stephen L. Yavelow to administer such medical/surgical care may be indicated for the diagnosis and treatment of the aforementioned patient.

I hereby authorize Dr. Stephen L. Yavelow to furnish my insurance company, attorney or any representative thereof, with any and all information, which may be requested regarding my past or present physical condition and medical treatment.

I further authorize my insurance company, attorney or other appropriate party to pay directly to Dr. Stephen L. Yavelow any and all medical/surgical expenses payable under the terms of my insurance contract or any legal settlement. Additional testing, such as hearing tests, indicated for diagnosis and treatment may incur charges not covered by your insurance company. In making this assignment I understand and agree that I am responsible for any cost insurred for legal or collection fees necessary to satisfy my financial obligation to Brandon Area Ear, Nose & Throat, P.A. including reasonable attorney fees, court costs, or collection expenses.

I understand and agree that photocopies of this form will be valid.

_____ _____

DATE SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____

RELATIONSHIP OF REPSONSIBLE PARTY TO PATIENT

❖ **I give consent for message to be left on my answering machine if applicable.**

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

❖ **I give consent for the release and/or obtaining of my medical records to further evaluate my treatment/care.**

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE OF BIRTH

_____

SOCIAL SECURTY NUMBER

❖ **THE FOLLOWING PERSON(S) HAVE MY PERMISSION TO OBTAIN MEDICAL INFORMATION**

_____ _____

_____ _____