Pinnacle ENT & Allergy Consultants
Phoenix: 16841 N. 31st Avenue, Bldg 2, Ste. 117, Phoenix, AZ 85053
Phone 602/843-4844 * Fax 602/843-4846

1.) Complete entirely or indicate N/A. 2.) Print clearly and sign authorization

PERSONAL INFORMATION

Name:_____ **Date of Birth:**_____
Last First MI

Sex:_____ **Marital Status:**_____ **Social Security No.:**_____

Email Address:_____ **Home Phone:**_____

ADDRESS **Work Phone:**_____

Street:_____

City:_____ **State:**_____ **Zip:**_____

Employed Retired Part Time Student Full Time Student (Circle One)

Employer:_____ **School:**_____ **Occupation:**_____

****Primary Care Physician/Pediatrician:**_____

****Pharmacy Information:**_____
Name Phone # / Cross Street

Parents (Responsible Parties)

Mother:_____ **Father:**_____

Date of Birth:_____ **SS#:**_____ **Date of Birth:**_____ **SS#:**_____

Home #:_____ **Work#:**_____ **Home #:**_____ **Work:**_____

Address:_____ **Address:**_____

City:_____ **State:**_____ **Zip:**_____ **City:**_____ **State:**_____ **Zip:**_____

Employer:_____ **Employer:**_____

Insurance Information

Specialist Co-pay $_____

Primary

Name:_____
ID#:_____ **Group#:**_____
Address:_____
Phone#:_____
Cardholder's Name:_____
DOB:_____ SS#:_____

Secondary

Name:_____
ID#:_____ **Group#:**_____
Address:_____
Phone#:_____
Cardholder's Name:_____
DOB:_____ SS#:_____

Patient Communication & Authorization

Emergency Contact Name:_____
Relationship to Patient:_____
Contact #:_____

THE FOLLOWING PERTAINS TO THE ABOVE NAMES PATIENT (CIRCLE ALL THAT APPLY)

Okay to Call Home and Leave Messages Don't Call Home Phone Okay to Call Work Number
Call Work Number Only Don't Call Work Number Okay to Receive Text Messages

OTHER THAN YOURSELF, TO WHOM MAY WE RELEASE YOUR PROTECTED HEALTH OR BILLING INFORMATION?

Pinnacle ENT & Allergy Consultants

INITIAL MEDICAL HISTORY
(Confidential)

Date:_____

To Our Patients:

Thank you for completing the following confidential history form. It will help us greatly in the overall evaluation of your problem. We will develop your history further in a few minutes in the examining room. Until then and thereafter, if you have any questions of our staff, please don't hesitate to ask.

Male ☐

Name:_____ **Age:**_____ **Birth Date:**_____ Female ☐

Last First Middle Initial

Referred to this office by:_____ **Currently under the care of a physician?** ☐ Yes ☐ No

If yes, whom?_____ **For what diagnosis?**_____

For what problem did you come to see the doctor today?_____

_____

_____

_____

_____

Have you been treated for an ear, nose or throat problem before? ☐ Yes ☐ No

M. D.'s Name:_____ **If yes, describe the previous problem:**_____

_____

List any medications currently taken or applied whether prescribed, over the counter or home remedy types:_____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No **If yes, please list:**_____

_____

If no, have you ever used tobacco? ☐ Yes ☐ No

If yes, how much?_____ **How long?**_____ **When did you quit?**_____

History of drug abuse? ☐ Yes ☐ No **History of alcohol use?** ☐ Yes ☐ No **If yes, how much?**_____

Previous surgeries:_____

_____

Any past history of: (If YES, please check and elaborate briefly below.) If NONE, please check here

☐ Asthma	☐ Diabetes	☐ Heart Trouble	☐ High Blood Pressure	☐ Nervous Disorder	☐ HIV
☐ Hay Fever	☐ Ulcers	☐ Liver Trouble/Hepatitis	☐ Kidney disease	☐ Bleeding Disorder	☐ Other
☐ Eczema	☐ Alcoholism	☐ Tuberculosis	☐ Eye Disease	☐ Bruising Easily	

Explain:_____

_____

_____

I certify that all the information listed above is, to the best of my knowledge, true and correct.

Patient Signature_____ **Date:**_____

(or guardian if patient is a minor under the age of 18 years old)

Nurse's Signature:_____ **Date:**_____

Reviewed and confirmed by:_____ **Date:**_____

Pinnacle ENT & Allergy Consultants

Brian S. Rizzo, D.O. • April D. Seiler, P.A.-C

Acknowledgement Form

- I, to the best of my knowledge gave the correct insurance information. I also understand that it is my responsibility to update any and all changes each visit. I have read the **insurance policy** in full and understand the policy.
- I have read and acknowledged Pinnacle ENT's **Appointment Policy.**
- I have read and understand Pinnacle ENT's **Billing** and **Financial Guidelines Policies**.
- I have read the **HIPPA** notice of **Privacy Practices Act**.

Patient Signature:_____ **Date:** _____

(or guardian if patient is a minor, under the age of 18 years old)

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