Upper Cumberland Ear, Nose & Throat

*Advanced care · Complete care · We care*

Patient Last Name _____ First Name _____ M.I. _____

Sex M F Date of Birth _____ Patient's SS# _____

Race (Optional): Asian Black Hispanic White/ Caucasian Other _____

Marital Status: Married Single Widowed Divorced Separated

Mailing Address _____ City _____ ST _____ ZIP _____

Preferred Contact Number: (_____) _____ Home / Cell

Alternate Phone Number: (_____) _____ Home / Cell

Emergency Phone Number: (_____) _____ Whose number is this? _____

How would you prefer we contact you regarding upcoming appointments: _____ Phone Call _____ Text

List anyone other than yourself that we may discuss your information with (i.e. billing, test results, appointments, etc):

_____ _____ _____

***Your Pharmacy*** _____

If Patient is a Minor:

Mother _____ Date of Birth: _____ SSN: _____

Father _____ Date of Birth: _____ SSN: _____

Guardian _____ Date of Birth: _____ SSN: _____

Person Responsible for Bill _____

Patient/Guardian Employer: _____ Work Phone _____

Spouse Name _____

Spouse Employer _____ Work Phone _____

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First Insurance Co. _____ Cardholder Name _____

Cardholder SS# _____ Cardholder Date of Birth _____

Policy/ID# _____ Group # _____

Second Insurance Co. _____ Cardholder Name _____

Cardholder SS# _____ Cardholder Date of Birth _____

Policy/ID# _____ Group # _____

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*Name of Doctor who sent you* _____ ***Family Doctor:*** _____

**How did you hear about our practice?** Physician Family Member/Friend Newspaper Internet/Website

***By signing below, I acknowledge that the UCENT Privacy Notice has been made available to me. I may receive a copy upon my request.***

Signature of Patient/ Guardian: _____ Date: _____

**Do you have hearing loss or tinnitus (ringing in the ears)? Yes No**
**Do you have sinus problems? Yes No**
**Do you snore or have sleep apnea? Yes No**

## PLEASE LIST ANY MEDICATION(S) THAT YOU ARE CURRENTLY TAKING:

| Name of Medication | Dosage | How Often Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ARE YOU ALLERGIC TO LATEX? _____YES _____NO**

**ARE YOU ALLERGIC TO ANY MEDICATION? ____YES _____NO If yes, please list:**

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |

**Current Weight:** _____ lbs **Current Height:** _____ ft _____in

**SURGERIES:**

**Have you ever had problems with anesthesia (being numbed or put to sleep? ___Yes ___No**

***If yes, please list type of problem:*** _____

_____

**List any surgeries you have had, including the year the surgery was performed:**

_____

_____

_____

_____