

Patient Information

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_
Address: \_\_\_\_\_ Sex: M F
City/State/Zip: \_\_\_\_\_ Marital Status: \_\_\_\_\_
Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_
Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_
Business Address: \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Whom may we thank for referring you to our office? (Circle one)
Other Physician:(Name) \_\_\_\_\_
Lecture \_\_\_\_\_ Medical Plan Referral Book Yellow Pages Friend \_\_\_\_\_
Newspaper (Name) \_\_\_\_\_ Medical Facility (name) \_\_\_\_\_
Other \_\_\_\_\_

Guarantor Information

Person responsible for account: \_\_\_\_\_
Relation to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec# : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Address (if different from patient): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_
Business Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is this an injury?

Date of accident: \_\_\_\_\_ Type of accident: \_\_\_\_\_ :employment related? Y

Insurance Information

Primary Insurance: \_\_\_\_\_ PIP Company:: \_\_\_\_\_
Secondary Insurance: \_\_\_\_\_ Adjuster Name: : \_\_\_\_\_

Pharmacy Information

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: (\_\_\_\_) \_\_\_\_\_

Assignment and Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the above noted insurance company and assign directly to Lisa Liberatore, M.D., all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only

PCP: \_\_\_\_\_ REF FORM: \_\_\_\_\_ CO-PAY AMT: \_\_\_\_\_

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:**

Please list the name and strength of the medications you are currently taking. (For example, Digoxin 0.125 mg. )

Name	Strength (e.g., 10 mg.)	Name	Strength

**Drug Allergies:**

Please list any drug allergies, including reactions. Please state NONE if no allergies.

Drug	Reaction	Drug	Reaction

**Non-Drug Allergies:**

Please list any food or non-drug allergies, including reactions. State NONE if no allergies. (For example, Latex, mold, milk, nuts, etc. )

Substance	Reaction	Substance	Reaction

**Past Illnesses**

Please circle Y or N if you have had any illnesses in the past.

- |            |   |   |                        |   |   |                     |   |   |              |   |   |
|------------|---|---|------------------------|---|---|---------------------|---|---|--------------|---|---|
| Anemia     | Y | N | Chronic fatigue        | Y | N | Hay Fever/Allergies | Y | N | Pneumonia    | Y | N |
| Arthritis  | Y | N | Coronary heart disease | Y | N | Heart murmur        | Y | N | Peptic ulcer | Y | N |
| Anxiety    | Y | N | Depression             | Y | N | Hepatitis           | Y | N | Psoriasis    | Y | N |
| Asthma     | Y | N | Diabetes I             | Y | N | Hypertension        | Y | N | Seizures     | Y | N |
| Bone       | Y | N | Diabetes II            | Y | N | Kidney stones       | Y | N | Stroke       | Y | N |
| Bronchitis | Y | N | Eczema                 | Y | N | Memory Loss         | Y | N | TB           | Y | N |
| Cataract   | Y | N | Glaucoma               | Y | N | Osteoporosis        | Y | N | Thyroid      | Y | N |

Cancer Y N

Please describe type of cancer and treatment you have received. (For example, radiation, chemotherapy, surgery)

Chicken Pox Y N Measles Y N Mumps Y N Rheumatic fever Y N Scarlet fever Y N

**Previous Surgeries**

Please list name and date of any past surgeries.

Surgery	Year

Height: \_\_\_\_\_

Weight: \_\_\_\_\_ Lbs

**Family History** Please circle if any blood relative has suffered any of the following:

- |              |            |                          |           |                 |                 |                  |
|--------------|------------|--------------------------|-----------|-----------------|-----------------|------------------|
| Alcoholism   | Anemia     | Anesthesia complications | Arthritis | Asthma          | Bleeding easily | Blindnes         |
| Cancer       | Crib death | Diabetes                 | Hay fever | Hearing Loss    | Heart disease   | High cholesterol |
| Hypertension | Migraines  | Renal (kidney) disease   | Stroke    | Thyroid disease |                 |                  |

**Social History** Please circle appropriate response:

- Use of alcohol:** Never Occasional/Social Moderate Daily
- Use of tobacco:** Never Previously, but quit in \_\_\_\_\_ Daily Packs/Day \_\_\_\_\_
- Is there a history of exposure to second hand smoke?** Y N
- Use of recreational drugs:** Never Previously, but quit in \_\_\_\_\_ Active use \_\_\_\_\_
- Is there a history of exposure to excessive noise?** Y N  Military  Work  Hobbies

**Review of systems** Please circle Y or N if you have had any of these symptoms.

Constitution	ENT	Snoring Assessment
Appetite Loss..... Y N	Ear ache/pain..... Y N	Do you snore ..... Y N
Bad breath/taste..... Y N	Ear drainage..... Y N	Has your snoring bothered other people..... Y N
Chills..... Y N	Ear infection..... Y N	Have you ever nodded off or fallen asleep while driving a vehicle..... Y N
Fatigue..... Y N	Ringing in ears..... Y N	Have you ever dozed off while sitting, inactive in a public place or while sitting and talking..... Y N
Fever..... Y N	Nose bleeds..... Y N	
Difficulty sleeping..... Y N	Sinus problems..... Y N	
Daytime sleepiness..... Y N	Sore throats..... Y N	
Weight Loss-recent..... Y N	Snoring..... Y N	
	Difficulty swallowing..... Y N	
<b>Other</b>	Prolonged hoarseness..... Y N	<b>Psychiatric</b>
Night sweats..... Y N	Decreased hearing..... Y N	Depression..... Y N
Travel out of U.S..... Y N	Decreased smell..... Y N	Anxiety..... Y N
Head banging..... Y N	Ear pulling..... Y N	Memory Loss..... Y N
Fussy/Irritable..... Y N		<b>Gastroenterology</b>
Speech/Language Difficulty..... Y N	<b>Respiratory</b>	Abdominal pain..... Y N
	Cough, chronic..... Y N	Bloody stools..... Y N
	Shortness of breath..... Y N	Constipation..... Y N
	On exertion..... Y N	Diarrhea..... Y N
<b>Eyes</b>	Lying flat..... Y N	Heartburn..... Y N
Blurred vision..... Y N	Coughing Blood..... Y N	Persistent Nausea..... Y N
Double vision..... Y N		Persistent vomiting..... Y N
Failing vision..... Y N	<b>Neurology</b>	
Eye pain..... Y N	Dizzy spells..... Y N	<b>Hematology</b>
<b>Musculoskeletal</b>	Headaches..... Y N	Easy bruising..... Y N
Muscle Weakens..... Y N	Numbness/tingling..... Y N	Transfusion history..... Y N
<b>Cardiovascular</b>	Fainting spells..... Y N	<b>Genitourinary</b>
Chest pain..... Y N		Blood in urine..... Y N
Swelling of ankles..... Y N	<b>Skin</b>	Frequent urinary infections..... Y N
Heart palpitations..... Y N	Rash..... Y N	

Patient Signature: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_