PRECISION ENT/ KADKADE MD PLLC **DATE:**_____

PATIENT LAST NAME:_____ FIRST NAME _____
DATE OF BIRTH: _____ SEX: M_____ F_____

STREET **ADDRESS**:_____ CITY_____ ST _____ ZIP _____

HOME #: (_____) _____ CELL #: (_____) _____ EMAIL:_____

WORK # (____) _____BUSINESS ADDRESS: _____

PRIMARY PHARMACY?: _____ LOCATION: _____

PHONE #: (_____)_____

REFERRED BY:_____ PHONE #: (____)_____FAX #:(____)_____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE #:(____)_____
ADVANCED DIRECTIVES: YES ____NO____

I give Dr. Kadkade permission to speak with the following people in regard to my care, appointments, insurance, billing, test results, etc. to the following:
Name: _____Relationship: _____ Phone #: (____)_____ Fax #:(____)_____

INSURANCE INFORMATION

POLICY HOLDER:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

PRIMARY INSURANCE:_____EFFECTIVE DATE: _____

POLICY/ID#_____ GROUP #_____ PHONE #:(____)_____

What is the specialist Co-pay, if any?_____

SECONDARY INSURANCE:_____EFFECTIVE DATE: _____

POLICY/ID#_____ GROUP #_____ PHONE #:(____)_____

The above information is true to the best of my knowledge. I have the above insurance coverage and assign directly to **KADKADE MD PLLC**, all insurance payments, if any, otherwise payable to me for services rendered. I also authorize Dr. Kadkade or my insurance company to release any information required to process my claims. I authorize the use of this signature on all insurance submissions. I understand that if I have a secondary insurance, my claim cannot be submitted until I provide Dr. Kadkade with the paperwork from my primary carrier. I understand that my claim will be submitted by Dr. Kadkade, on my behalf as a courtesy to me.

I understand that I may be financially responsible for some or all of the charges if not paid by insurance. I also understand that if the payment for services rendered is received by myself/guarantor/dependent from the insurance carrier, I will be charged 8.75% interest on the billed amount if the payment is not turned over to **KADKADE MD PLLC** within 30 days of receipt. I understand that I am responsible to send any EOB (Explanation of Benefits)/correspondence that I receive from my insurance carrier to the office in a timely manner.

Patient Name _____ Guarantor Signature _____ Date _____

PRECISION ENT **Kadkade MD PLLC** **Date:**

What are you here for today?

Past Medical History:

◯ Hypertension
◯ Kidney problems
◯ Respiratory Problems
◯ Neurological Problems
◯ Stomach/ Intestinal Problems
◯ Immune deficiency
◯ Diabetes
◯ Allergy problems/therapy
◯ Other _____
◯ Thyroid Problems
◯ Heart Disease/ High Cholesterol
◯ Hepatitis
◯ Facial fracture or trauma

Surgeries (Please list Date and Facility as possible):

_____

_____

_____

Medication(s): (Please list Dose and Times per day as possible):

_____

_____

_____

Any Allergies (including reactions to Drugs):_____

Family History:

◯ Bleeding disorder
◯ Allergy
◯ Hearing or Balance problems
◯ Anesthesia Problems
◯ Other _____
◯ Cancer
◯ Diabetes

Social History:

Do you smoke? ◯ YES ◯ NO What? _____How much per day? _____ How many years? _____

If no, did you smoke previously? ◯ YES ◯ NO How much per day? _____ How many years? ____When did you stop? _____

Do you drink alcohol? ◯ YES ◯ NO How much per day? _____ How many years? _____

Use recreational drugs? ◯ YES ◯ NO How much per day? _____ How many years? _____

What is your occupation? _____

Height_____ Weight_____ Vaccinations in past year (and approximate date)? _____

Review of your Systems: Please check if you presently have any of the following:

Allergy	◯ Sneezing ◯ Post nasal drip ◯ Seasonal allergy
ENT	◯Ear pain or itch ◯Ear drainage ◯Hearing loss ◯Ear noises ◯Dizziness, vertigo ◯ Lightheadedness ◯ Nasal congestion ◯ Sinus pressure/pain ◯ Nose Bleeds ◯ Sense of smell issues ◯ Recurrent Sinus infect ◯ Nasal discharge ◯ Problem snoring ◯ Snoring with pauses ◯ Hoarseness ◯ Throat pain ◯ Throat clearing ◯ Throat dryness/itching
Respiratory	◯ Cough ◯ Coughing blood ◯ Wheezing ◯ Shortness of breath ◯ Noisy breathing
Eyes	◯ Eye pain ◯ Watery/itchy eyes
GI	◯ Difficulty swallowing ◯Heartburn/reflux
Neuro	◯ Headache ◯ Passing out
General	◯ Chills ◯ Weight loss/gain ◯ Fatigue ◯ Daytime sleepiness
Endocrine	◯ Feel warmer than others ◯ Feel cooler than others
Heme/Lymph	◯ Swollen Glands ◯ Sweating at night ◯Bleeding Problems ◯ Easy Bruising
Cardiac	◯ Chest pain ◯ Palpitations
Musculoskeletal	◯ Joint aches ◯ Muscle Aches
Skin	◯ Rash ◯ Hives ◯ Itching ◯Skin/hair changes ◯ Strawberry birth mark
Psych	◯ Depression ◯ Anxiety/panic
Pain Assessment: Rate on a scale of 0 (none) to 10 (most severe):	