Welcome to Indianapolis Sinus Center

Patient Information:

Patient's Name: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: (____)_____ Alternate Phone: (_____) _____
Date of Birth: _____ Age: _____ Social Security Number: _____

Emergency Contact: _____ Relationship: _____

Employer/Occupation: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone Number: (____) _____

Preferred Method of Contact: _____
Restrictions regarding method of contact: _____

Family Physician: _____ Phone: _____
Referred By: _____ Phone: _____

Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced

Spouse Information

Name: _____
Date of Birth: _____ Social Security Number: _____
Employer/Occupation: _____
Employer Address: _____
Work Phone: (____) _____

Responsible Party:

Name: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
Employer: _____ Work Phone Number: (_____)_____
Address: _____

I have completed this form fully and completely, and certify that I am the patient or dully authorized agent of the patient to furnish the information requested. I also authorize the release of any medical information that pertains to the treatment that the patient or I receive.

Signature: _____ Date: _____

Today's Date: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Co Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Insurance ID#: _____
Group #: _____
Name of person who carries insurance: _____
Relationship to Patient: _____
Insured SSN #: _____
Insured Date of Birth: _____
Insured Employer: _____

Secondary Insurance

Insurance Co Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Insurance ID#: _____
Group #: _____
Name of person who carries insurance: _____
Relationship to Patient: _____
Insured SSN #: _____
Insured Date of Birth: _____
Insured Employer: _____

If your appointment is due to an injury, please answer the following questions:

- Did your injury occur on the job? _____Yes _____ NO
- If yes, please give date of injury: _____
- Did you report this injury to your employer? _____

Our office will gladly file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered services. See our financial policy for additional information.

Method of today's visit: _____ Cash _____ Check _____ Visa/MasterCard

Signature of Patient or Responsible Party: _____
Date: _____

I authorize the release of any medical information necessary to process my insurance claim.

Signature: _____ Date: _____
(Patient or Responsible Party)

I authorize payment and surgical benefits to _____ M.D.
(Name of Physician)

Signature: _____ Date: _____
(Patient or Responsible Party)

Today's Date: _____

PERSONAL MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE ILLNESSES, CONDITIONS AND/OR SYMPTOMS

G.I.

- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ GERD (acid-reflux)
- ❑ Vomiting Blood
- ❑ Bleeding
- ❑ Jaundice

CARDIOVASCULAR

- ❑ Chest Pain
- ❑ Distress on Exertion
- ❑ Breathe easily when upright only
- ❑ Sweat
- ❑ Faint
- ❑ Pacemaker
- ❑ Rheumatic Fever

EYES

- ❑ Pain
- ❑ Discharge
- ❑ Redness
- ❑ Light Sensitive
- ❑ Foreign Body
- ❑ Swelling
- ❑ Itching
- ❑ Double Vision

RESPIRATORY

- ❑ Rapid Breathing
- ❑ Wheezing
- ❑ Pleurisy
- ❑ Deep Chest Secretions
- ❑ Spitting up Blood
- ❑ Tuberculosis (TB)
- ❑ Disease
- ❑ Date of last chest x-ray:

UROLOGICAL

- ❑ Difficulty and/or painful urination
- ❑ Blood in urine
- ❑ Frequency urinating
- ❑ Side pain
- ❑ History of stones
- ❑ History of Pelvic Inflammation

NEUROLOGICAL

- ❑ Meningitis
- ❑ Headaches
- ❑ Confusion
- ❑ Numbness
- ❑ Weakness
- ❑ Seizures

GENERAL

- ❑ Pain
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Weakness
- ❑ Fatigue
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Stroke
- ❑ Heart Attack
- ❑ Ulcer
- ❑ Pulmonary Disease
- ❑ High Cholesterol
- ❑ Bleeding Tendency

- ❑ Blood Transfusion
- ❑ Psychiatric Issues
- ❑ Anxiety
- ❑ Depression
- ❑ Anemia
- ❑ Rash
- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox

MUSCULAR-SKELETAL

- ❑ Joint Swelling
- ❑ Joint Redness
- ❑ Joint Pain
- ❑ Gout
- ❑ Degenerative Joint Disease
- ❑ Rheumatoid Arthritis
- ❑ Joint Infection

Today's Date: _____

PERSONAL MEDICAL HISTORY
(If it does not apply, write the word "none")

List all Allergies (Food and Medicines): _____
_____

List all Surgeries (In-Patient & Out-Patient): _____
_____

List all Medications (Including dose & how often): _____
_____
_____

List all accidents or injuries to the neck or above (at any given point): _____
_____
_____

Medical reason for your visit to our office: List medications & how long you have been on for this problem: _____
_____

FAMILY MEDICAL HISTORY

Please indicate any significant health problems experienced by a member of your immediate family. Please also indicate if living or deceased and number of sibling(s).

Mother: __Living __Dead Health Problems_____
Father: __Living __Dead Health Problems_____
Brother(s): Number living____ Number dead____ Health Problems_____
_____
Sister(s): Number living___ Number Dead__ Health Problems_____
_____

Please list any illnesses that run in your family: _____
_____

Do you smoke? _____ If yes, how many packs per day_____? How many years have you smoked_____? Have you ever smoked and quit_____? If yes, when did you quit?_____

Do you drink alcohol? _____ If yes, how much and for how long? _____

Have you had any recent blood work done? _____
If yes, please indicate what type of blood work, when and where you had it done? _____
_____

Have you had any recent X-Rays or Scans performed? _____
If yes, please indicate what type of x-ray, when and where you had them performed? _____
_____