PACIFICA
Sarah Vakkalanka, M.D.
EAR | NOSE | THROAT

PERSONAL

Last Name: _____ First Name: _____M.I.____

Date of Birth: _____ Gender: Male · Female

Home Phone: _____ Cell Phone: _____

Email address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Guardian's Full Name *(if minor)*: _____

Patient SSN: _____ Guardian SSN: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Preferred Pharmacy Name: _____ Phone Number: _____

How did you hear about our office?

_____

INSURANCE

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance Company: _____

ID Number: _____ Group Number: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account due for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge**. I will notify Pacifica ENT of any changes in my health status or in the above information.**

Signature: _____ Date: _____

Patient Last Name: _____ Patient First Name: _____

Guardian's Signature *(if minor)*: _____

HIPAA PRIVACY RULES

Authorization of Disclosure in general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. **The patient may revoke or change this authorization at any time with a written request.**

1. I wish to be contacted by Pacifica ENT in the following manner:

   ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

2. I give permission for Pacifica ENT to:

   ☐ Leave a message with detailed information

   ☐ Send appointment reminders via text message

   ☐ Mail written communication to my home address

   ☐ Send written communication to my email address

Signature: _____ Date: _____

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Medical History Form

Name: _____ **Date:** _____

Current Medications: (Please include over the counter medications and supplements)

Name of Drug	Dosage (Strength)	Frequency (times per day)

If you are **currently not** on any medication please check this box: ☐

Drug Allergies:

Name of Drug	Reaction

If you have **no known allergies** please check this box: ☐

Review of Systems

Name: _____ Date: _____

Please check *yes* if you **currently** have the following symptoms.
If you **do not** have any of the following symptoms please check this box: ☐

ENT	YES		YES
Hearing Loss		Facial Pain	
Ringing in the ears		Loss of Smell	
Room spinning dizziness		Postnasal Drip	
Ear Pain		Snoring	
Ear Discharge		Difficulty Swallowing	
Runny Nose		Pain with Swallowing	
Hard to Breathe Through Nose		Hoarseness	
Itchy Nose		Nose Bleeds	
Lump in neck			

Neurologic	YES	**Cardiovascular**	YES	**General**	YES
Headaches		Chest Pain		Fever	
Numbness		Palpitations		Weight Loss	
Weakness		Shortness of Breath		Night Sweats	
Blurred Vision				Fatigue	
Double Vision					

Genitourinary	YES	**Musculoskeletal**	YES
Frequent Urination		Joint Pain	
Nocturnal Urination		Joint Swelling	
Painful Urination		Limited Mobility	

Integumentary	YES	**Psychiatric**	YES
Dry Skin		Sadness	
Changing of mole		Abnormal Mood	
Itchy Skin		Insomnia	