Mountain West
EAR NOSE & THROAT

Dr. Kevin M. Hanks
BOARD CERTIFIED
P: 208.542.5414 F: 208.552.2708

NAME _____ DATE OF BIRTH _____

Check all that apply

GENERAL

- ☐ *Fatigue*
- ☐ *Fever*
- ☐ *Weight Gain/Loss*
- ☐ *Pregnancy*

EYES

- ☐ *Double Vision*
- ☐ *Blurred Vision*
- ☐ *Eye Pain*

EAR | NOSE | THROAT

- ☐ *Ear Discharge*
- ☐ *Ear Pressure*
- ☐ *Vertigo/Dizziness*
- ☐ *Nasal Discharge*
- ☐ *Nasal Congeston*
- ☐ *Nasal Pain*
- ☐ *Nose Bleeding*
- ☐ *Snoring*
- ☐ *Hoarseness*
- ☐ *Change in Voice*
- ☐ *Lump Sensation in Throat*
- ☐ *Headaches*
- ☐ *Post Nasal Drip*
- ☐ *Blocked Ears*
- ☐ *Hearing Loss*
- ☐ *Decreased Sense of Smell*
- ☐ *Difficulty Swallowing*
- ☐ *Ear Pain*
- ☐ *Ringing in Ears*
- ☐ *Sinus Pain*
- ☐ *Sore Throat*
- ☐ *Swollen Glands*

CARDIOVASCULAR

- ☐ *Chest Pain*
- ☐ *Palpitations*
- ☐ *Hypertension*

RESPIRATORY

- ☐ *Cough*
- ☐ *Shortness of Breath*
- ☐ *Bloody Mucous*
- ☐ *Wheezing*

GASTROINTESTINAL

- ☐ *Nausea/Vomiting*
- ☐ *Painful Swelling*
- ☐ *Heartburn*
- ☐ *Belching*

SKIN

- ☐ *New Skin Lesions*
- ☐ *Changes to Skin Lesions*
- ☐ *Pigmentation Changes*

NEUROLOGICAL

- ☐ *Loss of Balance*
- ☐ *Tingling/Numbness*
- ☐ *Tremors*
- ☐ *Seizures*

MUSCULOSKELETAL

- ☐ *Muscle Aches*
- ☐ *Swollen Joints*
- ☐ *Painful Joint*

ENDOCRINE

- ☐ *Loss of Hair*
- ☐ *Cold Intolerance*
- ☐ *Heat Intolerance*

HEMOTOLOGY

- ☐ *Easy Bruising*
- ☐ *Easy Bleeding*
- ☐ *Enlargement or Tenderness*

ALLERGIC / IMMUNOLOGIC

- ☐ *Sneezing*
- ☐ *Itchy Water Burning Eyes*
- ☐ *Reaction to Anesthesia*

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NAME: _____ DATE: _____ SEX: MALE FEMALE

DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

Main reason for visit today: _____

When did the problem start: _____ Where/Which side: _____

What makes it better or worse: _____

Associated Systems: _____

Are you currently undergoing any treatment for this problem? _____

Current Medications	Including OTC & Herbal Supplements

Past Hospitalization/Surgeries	Where?

List any past *Medical History*	*Please be specific (ie: Diabetes, High Blood Pressure, Anemia, Stroke)*

DRUG ALLERGIES & YOUR REACTION: _____

Please list any life threatening illnesses in your IMMEDIATE family:

Mother: _____

Father: _____

Sibling: _____

PLEASE CHECK ALL THAT APPLY:

☐ *Smoke/have smoked?*
If current, how often? _____
If quit, when? _____

☐ *Consume Alcohol?*
How much? _____
How often? _____

☐ *Illicit Drugs?*
How much? _____
How often? _____

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First Name: _____ MI: _____ Last Name: _____

DOB: _____ AGE: _____ Social Security #: _____

Mailing Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____

SEX: __ MALE __ FEMALE MARITAL STATUS: __ Married __ Single __ Divorced __ Widow

RACE: __ White __ Hispanic __ African American __ Asian *Other*: _____

Ethnicity: _____ Preferred Language: _____

EMAIL ADDRESS: _____ Preferred PHARMACY: _____

EMPLOYER: _____ OCCUPATION: _____

How did you hear about Dr. Hanks? _____

Spouse/Guardian (if applicable): _____ DOB: _____

Phone: _____ Relationship to patient: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

SECONDARY INSURANCE: _____ POLICY #: _____

POLICY HOLDER: _____ POLICY HOLDER DOB: _____

RELEASE OF INFORMATION/HIPAA

I hereby authorize Dr. Hanks & staff to provide me with any and all necessary evaluations, therapies and/or treatments. I authorize Mountain West ENT to obtain any necessary medical information from any facility or doctor that will help in my diagnosis & care. They may release any information to my insurance company in order to process my claim.

I authorize Dr. Kevin Hanks to receive assignment of insurance payments. I understand that regardless of insurance coverage I am responsible for all charges & payments. I further understand that I can be charged for missed appointments. I agree to pay all deductibles, copays, coinsurance, and noncovered services. I agree that I will pay the 18% interest that will accrue after 90 Days. I am also aware that my account may be turned over to a third party collection service after 90 days of non payment.

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices online at drkevinhanks.com or in the office. I authorize Mt. West ENT to forward a copy of this to retrieve medical records to aid in my treatment.
I release Dr. Kevin Hanks from all legal responsibilty or liability due to insurance and/or correspondence descrepancies.
This authorization shall continue to be enforced and effective until revoked in writing by me, the responsible party.

Responsible Party Signature: _____ *DATE:* _____

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Authorization of Release of Information to Family Members

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Mountain West ENT to release my medical and/or billing information to the following individual(s):

1. _____ *Relation to Patient:* _____

2. _____ *Relation to Patient:* _____

3. _____ *Relation to Patient:* _____

PATIENT INFORMATION

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient Signature _____ *DATE:* _____