# INFORMATION FOR CASE HISTORY

Patient's name _____ Date of birth _____
First Middle Last

Married ☐ Unmarried ☐ Widowed ☐ Age _____ Male ☐ Female ☐

Home address _____ City _____ Zip Code _____

Home phone _____ Cell phone _____ Social Security _____

Email address _____

Employer _____ Phone _____

Address _____ City _____ Occupation _____

Name of spouse (parent or guardian if minor) _____

Employer _____ Phone _____

Address _____ City _____ Occupation _____

Referred by _____

Emergency contact _____ Phone _____

What is your main complaint? _____

Do you have any of the following?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Ear aches | ☐ | ☐ | Dizziness |
| ☐ | ☐ | Ear drainage | ☐ | ☐ | Hoarseness |
| ☐ | ☐ | Difficulty hearing | ☐ | ☐ | Coughing |
| ☐ | ☐ | Sinus problems | ☐ | ☐ | Sore glands |
| ☐ | ☐ | Difficulty breathing through your nose | ☐ | ☐ | Allergies - Specify _____ |
| ☐ | ☐ | Sore throats | ☐ | ☐ | Drug Reactions - Specify _____ |
| | | | ☐ | ☐ | Are your tonsils out? |

If patient is less than age 18, a parent or guardian must sign below to authorize treatment.

Signature of parent or guardian _____

## INSURANCE INFORMATION

Primary Insurance

Insurance Company _____ Phone _____

Insured Name _____

Social Security # _____

Group Name or # _____

Patient Relationship To Insured Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Secondary Insurance

Insurance Company _____ Phone _____

Insured Name _____

Social Security # _____

Group Name or # _____

Patient Relationship To Insured Self ☐ Spouse ☐ Child ☐ Other ☐ _____

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ALAN J. FISHER, MD FOR ALL INSURANCE BENEFITS DUE FOR SERVICES FURNISHED. I AUTHORIZE ALAN J. FISHER, MD TO RELEASE THE INFORMATION REQUIRED TO RECEIVE PAYMENT OF BENEFITS.

I UNDERSTAND THAT SOME SERVICES RENDERED BY THIS OFFICE ARE NOT COVERED BY INSURANCE BENEFITS. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL THOSE INCURRED CHARGES.

SIGNATURE: _____

DATE: _____