TOTUM ENT
LISA LIBERATORE, MD

Lisa A. Liberatore, MD
154 East 85th Street, New York, NY 10028

New Patient Information

Patient: ____________ DOB: ____________ Age: ________ Date: ____________

Home Phone: ____________ Cell Phone: ____________

Address: ____________ Sex: ☐ M ☐ F

City/State/Zip: ____________ Marital Status: ____________

Soc Sec # ____________ Email Address: ____________

Patient Employed By: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

City: ____________ State: ____________ Zip Code: ____________

Emergency Contact: ____________ Phone: ____________

Whom may we thank for referring you to our office?

☐ Other Physician: (Name) ____________

☐ Medical Plan Referral Book ☐ Medical Facility: (Name) ____________

☐ Media ☐ Internet ☐ Friend

☐ Other ____________

Would you be interested in participating in our Wellness Program? ☐ Yes ☐ No

Guarantor information

Person responsible for account: ____________

Relation to Patient: ____________ Birthdate: ____________ Soc Sec#: ____________

Address (if different from patient): ____________ Phone: ____________

Employed By: ____________ Occupation: ____________

Business Address: ____________ Phone: ____________

City: ____________ State: ____________ Zip Code: ____________

Insurance Information

Primary Insurance: ____________ PIP Company: ____________

Secondary Insurance: ____________ Adjuster Name: ____________

Pharmacy Information

Pharmacy Name: ____________ Pharmacy Phone: ____________

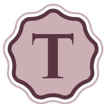
Assignment and Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the above noted insurance Company and assign directly to Lisa A. Liberatore, MD, all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance, hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have received the Notice of Privacy Practice, and have been provided an opportunity to review it.

Signature: ____________ Relationship: ____________ Date: ____________

Office Use Only

PCP: ____________ REF FORM: ____________ CO-PAY AMT: ____________



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Name: ______ Gender: ______ Age: ______ Date of Appointment: ______

Reason for Visit

What brings you to the office today?

______

Height ______ Weight ______ BMI ______

Current Medication

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Have you ever been allergy tested?

☐ Yes ☐ No When? ______

Have you ever had allergy shots?

☐ Yes ☐ No When? ______

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

ENT

Do you have any of the following?

☐ Bleeding Gums
☐ Blurred Vision
☐ Clicking in Ears
☐ Crossed Eyes
☐ Decreased Sense of Smell
☐ Decreased Sense of Taste
☐ Difficulty Breathing
☐ Difficulty Swallowing
☐ Dizziness
☐ Double Vision
☐ Earaches
☐ Ear Discharge
☐ Facial Paralysis
☐ Hay Fever
☐ Hoarseness
☐ Hearing Loss
☐ Itching in Ears
☐ Lumps / Knots in Neck
☐ Nasal Obstruction
☐ Neck Pain
☐ Nose-Bleeds
☐ Persistent Cough
☐ Persistent Runny Nose
☐ Recurring Sore Throat
☐ Ringing in Ears
☐ Sinus Problems
☐ Snoring
☐ Throat Pain
☐ Vision Halos

Past Medical History

Do you have any of the following?

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ AIDS / HIV
☐ Back Problems
☐ Bleeding Disorder
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Depression
☐ Ear Problems
☐ Eating Disorder
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Heart Problems
☐ Hepatitis- A, B, or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Joint Disorder
☐ Kidney Disorder
☐ Liver Disorder
☐ Lung Disorder
☐ Measles
☐ Migraines
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Stroke
☐ Skin Disorder
☐ Stomach Ulcer
☐ Substance Abuse
☐ Thyroid Disorder
☐ Tuberculosis
☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism
☐ Allergies
☐ Alzheimer`s
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ AIDS/HIV
☐ Bleeding Disorder
☐ Blood Disorder
☐ Cancer
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Genetic Disorder
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Joint Disorder
☐ Kidney Disease
☐ Liver Disorder
☐ Lung Disease
☐ Migraines
☐ Psychiatric Disorders
☐ Osteoporosis
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years ______ # packs/day ______

Do you smoke now?

☐ Yes ☐ No # packs/day ______

Do you use recreational drugs?

☐ Yes ☐ No types? ______ # times/week ______

How much alcohol do you drink per week?

drinks/week ______

How much caffeine do you drink per week?

drinks/day ______

______

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Name: ________________ Gender: ________ Age: ____ Date of Appointment: ____________

Review of Systems

General

- [ ] Chills
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Hair Loss
- [ ] Hair Growth - Excessive
- [ ] Night Sweats
- [ ] Sleeping Problems
- [ ] Thirst - Excessive
- [ ] Weight Gain
- [ ] Weight Loss

Mental Health

- [ ] Anxiety
- [ ] Depression
- [ ] Loss of Interest
- [ ] Feeling Hopeless
- [ ] Hearing Voices
- [ ] Marital Problems
- [ ] Panic Attacks
- [ ] Trouble Concentrating
- [ ] Suicide-Thoughts / Attempts

Genitourinary

- [ ] Blood in Urine
- [ ] Lack of Bladder Control
- [ ] Frequent Urination
- [ ] Painful Urination

Gastrointestinal

- [ ] Appetite Gain
- [ ] Appetite Loss
- [ ] Bloating
- [ ] Bowel Changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Intestinal Disorder
- [ ] Lactose Intolerance
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting Blood

Neurological

- [ ] Coordination Problems
- [ ] Convulsions
- [ ] Difficulty Walking
- [ ] Learning Disabilities
- [ ] Light-headedness
- [ ] Memory Loss
- [ ] Numbness / Tingling
- [ ] Paralysis
- [ ] Seizures
- [ ] Speech Problems
- [ ] Tremors

Skin

- [ ] Chills
- [ ] Acne
- [ ] Bruise Easily
- [ ] Changes in Moles
- [ ] Dry / Sensitive Skin
- [ ] Eczema
- [ ] Hives
- [ ] Itching
- [ ] Rash
- [ ] Scars
- [ ] Scores That Won't Heal

Respiratory

- [ ] Coughing
- [ ] Coughing Up Blood
- [ ] Shortness of Breath
- [ ] Wheezing

Cardiovascular

- [ ] Chest Pains
- [ ] Irregular Heart Beat
- [ ] Circulation Problems
- [ ] Heart Palpitations
- [ ] Rapid Heartbeat
- [ ] Swelling of Ankles
- [ ] Varicose Veins

Musculoskeletal

- [ ] Back Pain
- [ ] Carpal Tunnel Syndrome
- [ ] Joint Pain
- [ ] Joint Swelling
- [ ] Neck Pain
- [ ] Shoulder Pain

Women Only

- [ ] Abnormal Pap Smear
- [ ] Bleeding between Periods
- [ ] Breast Lump
- [ ] Extreme Menstrual Pain
- [ ] Hot Flashes
- [ ] Nipple Discharge
- [ ] Painful Intercourse
- [ ] Vaginal Discharge

Other Symptoms

____

____

____

Lisa A. Liberatore, MD

____________________ ____________
Physician Signature Date