

# Patient Health History

## Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark

Incorrect Marks



DIRECTION OF FEED

1. Are you allergic to any of the following?

Adhesive tape	<input type="checkbox"/>	Yes	Metal	<input type="checkbox"/>	Yes
Iodine	<input type="checkbox"/>		Seafood	<input type="checkbox"/>	
Latex	<input type="checkbox"/>		Contrast Dye	<input type="checkbox"/>	

Name: \_\_\_\_\_

Date of Appt: \_\_\_\_\_

4. Mark if retired.  Yes

2. Mark if you have been diagnosed with any of the following:

Breast Cancer	<input type="checkbox"/>	Yes	Gastrointestinal	<input type="checkbox"/>	Yes
Lung Cancer	<input type="checkbox"/>		Reflux	<input type="checkbox"/>	
Skin Cancer	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	
Throat Cancer	<input type="checkbox"/>		Stomach Ulcer	<input type="checkbox"/>	
Prostate Cancer	<input type="checkbox"/>		Are you pregnant?	<input type="checkbox"/>	
Other Cancer	<input type="checkbox"/>		Prostate Enlargement	<input type="checkbox"/>	
Migraine Headache	<input type="checkbox"/>		Renal Failure	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>		Anxiety	<input type="checkbox"/>	
Nasal Allergies	<input type="checkbox"/>		Depression	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	
Blood Clots/DVT	<input type="checkbox"/>		Thyroid Dysfunction	<input type="checkbox"/>	
High/Elevated Cholesterol	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>		Hemophilia	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		HIV	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>				
Chronic Bronchitis	<input type="checkbox"/>				
Emphysema	<input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>				

5. Tobacco Use:  
Mark your tobacco use.  
 None  Cigarettes  
 Smokeless Tobacco  Cigars

Give the closest amount of cigarettes you smoke in an average day.

- 1/2 pack  2 packs  
 1 pack  3 packs  
 1 1/2 packs

Alcoholic Beverages - A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.

- Less than 12 drinks/yr  
 1-13 drinks/mo  
 4-14 drinks/wk  
 >2 drinks/day

6. Do you use drugs recreationally?  Yes

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):  
 None  2-3 per day  
 1 per day  4 or more

8. Are you exposed to second hand smoke?  Yes

9. Mark if patient attends daycare.  Yes

10. Will you accept transfusion of blood products if necessary?  Yes

11. Home Living Situation (mark all that apply).  
 Alone  With spouse  
 With children  In nursing home  
 With mother  With father  
 In assisted living  Other

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unspecified Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss before age 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss after age 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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12. Do you now have or have you recently had any of the following?--

	Yes
Fever	<input type="checkbox"/>
Sleeping problems	<input type="checkbox"/>
Unintentional weight loss	<input type="checkbox"/>
Unintentional weight gain	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>
Painful eye	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Ear drainage	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>
Post-nasal drainage	<input type="checkbox"/>
Belching sour material into throat	<input type="checkbox"/>
Hoarseness or other voice changes	<input type="checkbox"/>
Mouth ulcers	<input type="checkbox"/>
Partials or dentures	<input type="checkbox"/>
Blacking out or fainting	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>
Irregular heartbeats	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>
Swelling of ankles	<input type="checkbox"/>
Frequent non-productive cough	<input type="checkbox"/>
Frequent productive cough	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>
Snoring (excessive)	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>
Nausea	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>
Painful swallowing	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>
Painful joints	<input type="checkbox"/>
Stiffness in joints	<input type="checkbox"/>
Swelling of joints	<input type="checkbox"/>

12. Do you now have or have you recently had any of the following? (continued)

	Yes
Change in sense of smell	<input type="checkbox"/>
Change in sense of taste	<input type="checkbox"/>
Headache	<input type="checkbox"/>
Severe face pain	<input type="checkbox"/>
Seizures	<input type="checkbox"/>
Tremor	<input type="checkbox"/>
Appetite is increased	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Cold feeling	<input type="checkbox"/>
Bleed excessively after injury	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>
Masses (lumps) in armpit	<input type="checkbox"/>
Masses (lumps) in neck	<input type="checkbox"/>
Masses (lumps) in groin	<input type="checkbox"/>
Hives	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>

Thank you  
for  
completing  
this  
questionnaire!

# Coastal Carolina ENT

Otolaryngology-Head and neck surgery- Facial plastic and Cosmetic Surgery- Allergy

ERIC KENYON, DO

JAMES DIMUZIO, DO

MATTHEW BRENNAN, DO

JEFEREY G. CORY, DO

MICHAEL D. PETERS, MD

SAVANNAH WARD, NP

TODD STUGART, NP

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ (This is needed for insurance purposes only)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Gender: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

\*\*\* Statements will be sent by email. If you prefer to be sent by USPS, please check here. \_\_\_\_\_

### FINANCIALLY RESPONSIBLE: (other than the patient)

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### PLEASE READ AND SIGN BELOW:

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits to be made directly to COASTAL CAROLINA ENT. Any balance left after insurance payment has been received will be due within 90 days of notification from this office. I further understand that any sums due to me, if less than \$100.00, will be credited to my medical account. If sums due to me are more than \$100.00, a check will be issued and mailed to address given. This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

I have read and understood all of the above and have given truthful information to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

302 Liberty Street  
Whiteville, NC 28472  
(910) 914-0540(P)  
(910) 914-0640(F)

2298 Ocean Hwy W  
Supply, NC 28462  
(910) 755-3682(P)  
(910) 755-6923(F)

3806 Sawtell Rd  
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(843) 663-9091(F)

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(910) 754-7913(P)  
(910) 754-4284(F)



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SAVANNAH WARD, NP    TODD STUGART, NP

## Designation of Caregivers for Communication of Protected Health Information

Patient Name: \_\_\_\_\_ Current Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

At my request, I authorize the person(s) below to inquire about my personal health and/or billing information on my behalf. In case of a minor, this person(s) may inquire about their child's personal health and/or billing information. If necessary, this person may bring the child to appointments on my behalf.

Name	Relationship	DOB	Phone Number

**OR**

\_\_\_\_\_ (initial) I DO NOT want my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize COASTAL CAROLINA ENT to communicate my protected health information to me via the following methods: (Check all that apply)

- Leave a DETAILED MESSAGE on my HOME voicemail: Phone Number: \_\_\_\_\_
- Leave a DETAILED MESSAGE on my CELL voicemail: Phone Number: \_\_\_\_\_
- Leave a MESSAGE with CALL BACK number only. Phone Number: \_\_\_\_\_
- Leave a DETAILED MESSAGE on my WORK voicemail Phone Number: \_\_\_\_\_
- FAX DETAILED medical information to ME: Fax Number: \_\_\_\_\_

Authorized Patient or Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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 SAVANNAH WARD, NP    TODD STUGART, NP

## PATIENT SCREENING

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ "

Please indicate if you have had the following screenings and/or vaccinations.

If so, when were they done?

	<u>Yes</u>	<u>No</u>	<u>When/Last?</u>
Influenza Vaccine (Flu Vaccine)	_____	_____	_____
Tdap Vaccination (Tetanus)	_____	_____	_____
Herpes Zoster Vaccination (Shingles)	_____	_____	_____
Pneumococcal Vaccine (Pneumonia Vaccine)	_____	_____	_____
Current Smoker	_____	_____	_____
Advance Care Plan (List Person)	_____	_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## DIAGNOSTIC SCOPE/PROCEDURE

If you are here for a **SINUS OR THROAT** issue, the doctor may need to perform a diagnostic scope/procedure. A nasal endoscopy is a procedure to look at the nasal and sinus passages. It's done with an endoscope. This is a thin, flexible, or rigid tube with a tiny camera and a light. If this procedure is needed, your doctor will speak to you beforehand.

We want to inform you that there will be an additional charge sent to your insurance company this. Some insurance companies will bill this as a "surgery" and this charge may go towards your deductible.

If you are a self-pay patient, this will be an additional charge needing to be paid at time of check-out.

I agree to have this scope/procedure done and I will be responsible for any bills that may occur in reaction to this.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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COASTAL CAROLINA ENT, DO, PA  
PATIENT PRIVACY HIPAA NOTICE FORM

ERIC KENYON, DO

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TODD STUGART, NP

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was created to provide a standard for health providers to obtain their patient's consent for use and disclosure of health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we assure you that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we only provide the minimum information required to those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

In addition, please note that we request full access to your personal medical records. We may have direct treatment relationships (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations.

You may refuse to authorize the use or disclosure of your personal health information, but this MUST be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your PHI (Personal Health Information). Please be aware that signing, you may not ask to revoke and refuse PHI.

If you have any objections to this form, you have a right to speak to our HIPAA Compliance officer.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

COASTAL CAROLINA ENT, DO, PA

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to be certain that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability (HIPAA) with particular emphasis on the "PRIVACY RULE". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We know that we are not perfect, and because of this, our policy is to listen to our employees and our patients without any thought of penalization if they feel that in any way a compromise has been made against our PHI.

Thank you for choosing Coastal Carolina ENT.

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