PATIENT INFORMATION (PLEASE PRINT & FILL OUT COMPLETELY) Date:_____

Patient's Name: _____ M.I. _____ Last: _____

Date of Birth: _____ Age:_____ Sex: ☐ M ☐ F

Social Security Number: _____-_____-_____ Email: _____

Patient's Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Mobile Phone:_____

Person Financially Responsible: ***SELF (☐)*** ***SPOUSE (☐)*** ***PARENT (☐)*** ***OTHER ( )***

Name of responsible Person:_____ _____**Date of Birth:**_____

Social Security Number: _____-_____-_____ **Home Phone**:(_____)_____**Mobile Phone**: (_____)_____

Emergency Contact: _____ Phone: (_____)_____
Relationship to Patient: _____

Pharmacy Name:_____ Address _____

FAMILY PHYSICIAN_____

Information Regarding a Minor Child

Marital Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other:_____

IF **NOT MARRIED**, Who Has Custodial Rights: ☐ Mother ONLY ☐ Father ONLY ☐ Both Parents ☐ Other:_____

Father's Name: _____ DOB: _____ Mobile Phone: (_____)_____
Name of Employer: _____ Work Phone: (_____)_____

Mother's Name: _____ DOB: _____ Mobile Phone: (_____)_____
Name of Employer: _____ Work Phone: (_____)_____

PLEASE READ: **Payment is required IN FULL at the time of each visit**. The patient, their parent, or their guardian are responsible for all fees, regardless of insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.

RELEASE OF INFORMATION:
I authorize the release of medical information necessary to process insurance claims.

INSURED OR AUTHORIZED PERSON'S SIGNATURE
I authorize and request payment of medical benefits to be paid directly to Dr. Mongiardo.

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO AND SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I ALSO CERTIFY THAT I AM THE FINANCIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name _____ **Relationship**_____

Signature _____ **Date** _____

Please fill in YES OR NO to all that apply to you AT THIS TIME

Symptom	YES	NO
CHILLS	☐	☐
FEVER	☐	☐
CONGESTION	☐	☐
SNEEZING	☐	☐
BLURRED VISION	☐	☐
DOUBLE VISION	☐	☐
BLOCKED EAR	☐	☐
DECREASED HEARING	☐	☐
EAR PAIN	☐	☐
RINGING IN THE EAR	☐	☐
THYROID PROBLEMS	☐	☐
DIABETES	☐	☐
OBSTRUCTIVE SLEEP APNEA	☐	☐
SNORING	☐	☐
COUGH	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PALPITATIONS	☐	☐
DIFFICULTY SWALLOWING	☐	☐
HEARTBURN	☐	☐
DIZZINESS	☐	☐
HEADACHE	☐	☐
EASY BRUISING	☐	☐
EASY BLEEDING	☐	☐
PAINFUL JOINTS	☐	☐
JOINT STIFFNESS	☐	☐
SUSPICIOUS SKIN LESIONS	☐	☐
RASH	☐	☐
ANXIETY	☐	☐
DEPRESSED MOOD	☐	☐

PATIENT NAME:_____

PAST Medical History: Please fill in all that apply to YOU

HISTORY	YES	NO
Tobacco Use	☐	☐
Smokers in the Home	☐	☐

FAMILY HISTORY: EXAMPLE: Mom, Dad, Grandmother or Grandfather

☐ CANCER ☐ THYROID DISEASE ☐ HYPERTENSION ☐ DIABETES ☐ HEART DISEASE

PATIENT HISTORY

PATIENT HISTORY	YES	NO
THYROID DISEASE	☐	☐
HYPERTENSION	☐	☐
ASTHMA	☐	☐
DIABETES	☐	☐
DIABETES INSULIN DEPENDENT	☐	☐
HEART DISEASE	☐	☐
CANCER	☐	☐
LUNG DISEASE	☐	☐
KIDNEY DISEASE	☐	☐

PAST SURGERIES

SURGERY	YES	NO
TONSILS	☐	☐
ADENOIDS	☐	☐
EAR	☐	☐
NASAL/SINUS	☐	☐
LUNG	☐	☐
HEART	☐	☐
ABDOMINAL	☐	☐
JOINT/BONE	☐	☐
PROSTATE	☐	☐
GYN	☐	☐
URINARY/KIDNEY	☐	☐
SPINE	☐	☐
VASCULAR	☐	☐
THROAT/NECK	☐	☐
LIST ANY MEDICINE ALLERGIES:		

PATIENT NAME:_____

APPALACHIAN REGIONAL HEAD & NECK CENTER

Frank D. Mongiardo, M.D., P.S.C.

Date:_____

I give permission to the offices of Frank Daniel Mongiardo, M.D. to release protected health information to the following family members on my behalf. This authorization includes but is not limited to paper/electronic medical records, personal information such as date of birth, insurance companies, prescriptions and patient accounts. This authorization remains in full force until revoked in writing.

☐ **Do not release any information to any family member**

The following family members may have my information released to them: PLEASE PRINT

_____

_____

_____

_____

Signed_____ **Date**_____

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email: drmongiardo@drmongiardo.com URL: www.drmongiardo.com