HJ Obeid, MD, PLLC
Ears, Nose & Throat / Sinus Center
91 Perimeter Road, Suite 180, Rome, NY 13441
2407 Genesee Street, Utica, NY 13501
315.336.8302 Fax: 315.339.0958

New Patient Forms

Patient Name: _____Date of Birth: _____
Address: _____
_____
Home Phone: ( ) _____ Cell: ( ) _____ Other: ( )_____

ALL MINOR CHILDREN MUST BE ACCOMPANIED BY PARENT OR LEGAL GUARDIAN.

Please add parent / guardian information below for our records.
Name:_____ Cell: ( ) _____

Primary Care Physician: _____
Referring Physician: _____

Please note ALL NEW PATIENTS MUST HAVE INSURANCE CARD with them at the time of the first visit or the appointment will be rescheduled.

Insurance Company: _____
ID Number: _____ **Subscriber:**_____

Is the reason for your visit related to an accident or injury? ☐YES ☐ NO
If yes please give a brief explanation of accident/injury:_____
_____

If you are using **NO FAULT or WORKERS COMP Please Have That Information at The Time of First Visit.**
Company Name: _____ Claim Number: _____
Address:_____
Contact:_____ Phone:_____

Please indicate the reason you are seeing Dr. Obeid today: _____
_____

Have you had any testing including hearing tests that are related to the reason of your visit today: ☐YES ☐ NO

☐ CT SCAN ☐ MRI ☐ X-RAY ☐ Hearing Test ☐ Other:_____ When:_____

If yes please indicate the facility of the test(s): _____

_____

Regarding the reason for your visit please answer the following questions:

How long have you had the problem: _____

Have you tried any over-the-counter medications? (If YES please list) _____

_____

Were you prescribed any medications by another doctor for this problem? (If YES please list) _____

_____

_____

Patientôs Health History Form

Height: _____ **Weight**: _____

Date of last medical examination: _____

List any surgeries you have had: _____

_____

List any medications you are currently taking: (attach a list if needed)

_____

_____

List any medical problems you may have:

O Asthma O High Blood Pressure O Diabetes O Heart Conditions O High Cholesterol O Sleep Apnea

O Seasonal Allergies O Liver Disease O Kidney Disease O Depression O Migraines O TMJ O Cancer

Other: _____

List any symptoms you may have:

O Ear pain O Difficulty/changes in hearing OWax build up O Headaches O Sinus pain O Facial pain O trouble smelling O Post nasal drip O Stuffiness O Allergy symptoms O Sore throat O Voice issues O Jaw pain

O Difficulty sleeping O Snoring O Loss of energy O Dizziness

Other _____

Do you currently wear hearing aids?: ☐YES ☐NO How long:_____

Do you smoke? ☐YES ☐NO How much per day: _____

For how long: _____

Do you consume alcohol? ☐YES ☐ NO **How often**: _____

Do you exercise regularly? ☐YES ☐ NO

RELEASE OF INFORMATION:

To: _____ Phone:_____

Please forward copies of my records including requested test results to Dr. Obeidôs Office listed below to assist in my care / treatment.

HJ Obeid, MD, – ENT
91 Perimeter Road, Suite 180
Rome, NY 13441
PH: 315.336.8302 FAX: 315.339.0958

_____ _____

Patientôs Name: Date of Birth:

_____ _____

Signature of Patient / Guardian: Todayôs Date: