METSON & SCANGAS

Ralph B. Metson, MD & George A. Scangas, MD
Otolaryngology | Nasal and Sinus Surgery

PATIENT INFORMATION

NAME:					DOB:		AGE:	SEX:	
HOME ADDRESS:					CITY:		STATE:	ZIP:	
PRIMARY PHONE:		H	W	C	SECONDARY PHONE:			H	W	C
MARITAL STATUS:	S	M	D	W	OCCUPATION:		EMPLOYER:			
EMERGENCY CONTACT #1:					PHONE:		RELATIONSHIP:			

REFERRING DOCTOR:	ADDRESS:	PHONE:	FAX:
PRIMARY CARE PHYSICIAN:	ADDRESS:	PHONE:	FAX:
PHARMACY:	ADDRESS:	PHONE:	FAX:

INSURANCE INFORMATION

PRIMARY INSURANCE:		I.D./POLICY #		GROUP #:	
SUBSCRIBER NAME:		DOB:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:		
			SELF	SPOUSE	CHILD	OTHER
EMPLOYER:	ADDRESS:	PHONE:			

SECONDARY INSURANCE:		I.D./POLICY #		GROUP #:	
SUBSCRIBER NAME:		DOB:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:		
			SELF	SPOUSE	CHILD	OTHER
EMPLOYER:	ADDRESS:	PHONE:			

RELEASE OF INFORMATION

- **I authorize payment of medical benefits by my insurance company to Ralph Metson, M.D., P.C. I understand that payment of patient portion of insurance coverage such as copay, deductible and/or co-insurance must be paid within 90 days from date of service or account may be forwarded to collection agency.**
- **I authorize the release of any information pertinent to the processing of my medical claims.**
- **I authorize any images taken of me by Dr. Metson/Dr. Scangas to be used at his discretion for the purposes of medical education or research including publication on websites or in medical journals.**

SIGNATURE OF PATIENT/GUARDIAN/POLICYHOLDER: _____	DATE: _____

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MEDICATIONS

DRUG NAME	DOSE	INSTRUCTIONS

How many courses of antibiotics have you been on in the past year?	0	1-2	3-4	5+
Have you taken nasal steroid sprays?	YES	NO	FOR HOW LONG? _____	

ALLERGIES

ALLERGY	REACTION

MEDICAL HISTORY

	DATE	HOSPITALIZATIONS & MAJOR ILLNESSES
HOSPITALIZATIONS & MAJOR ILLNESSES		

	DATE	SURGERY
SURGERIES		

	Y	N		Y	N	
HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?			ASTHMA			HIGH BLOOD PRESSURE
			ABNORMAL BLEEDING			NERVOUS DISORDER
			HEART DISEASE			TUBERCULOSIS
DO YOU HAVE:			DIABETES			PACEMAKER

SMOKING		NEVER SMOKED	SMOKERS/FORMER SMOKERS
		SMOKE SOME DAYS	YEARS SMOKED
		SMOKE EVERY DAY	PACKS PER DAY
		FORMER SMOKER	_____ QUIT DATE
SMOKELESS TOBACCO		NEVER USED	FORMER USER
		CURRENT USER	_____ QUIT DATE

	Y	N		Y	N	
FAMILY HISTORY M (Mother) F (Father) S (Sister) B (Brother) O (Other Relative)			ABNORMAL BLEEDING			HEARING LOSS
			CANCER			HEART DISEASE
			DIABETES			STROKE

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