Steve Y Kim, MD
Ears, Nose, and Throat

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New Patient Registration & Medical History

Today's date _____ Office: ☐ Flushing, NY ☐ Fort Lee, NJ

PATIENT INFORMATION

Last name _____ First name _____ M.I. _____

Date of birth _____ Sex: ☐ M ☐ F ☐ Other _____ Preferred language _____

Street address _____

City _____ State _____ ZIP _____

Cell phone _____ Email _____

Referring physician _____ Primary care physician _____

Emergency contact _____ Relationship _____ Phone _____

INSURANCE

Primary insurance _____ Member ID _____

Policy holder name _____ Policy holder date of birth _____

Secondary insurance _____ Member ID _____

Please bring your insurance card(s) and a photo ID to your visit.

REASON FOR VISIT

What brings you in today? _____

How long have you had this problem? _____ Which side? ☐ Left ☐ Right ☐ Both

CURRENT SYMPTOMS (check all that apply)

Ears ☐ Hearing loss ☐ Ringing (tinnitus) ☐ Ear pain ☐ Drainage ☐ Fullness / pressure ☐ Wax build-up

Balance ☐ Dizziness ☐ Spinning (vertigo) ☐ Unsteadiness ☐ Motion sensitivity

Nose & Sinus ☐ Congestion ☐ Sinus pressure ☐ Post-nasal drip ☐ Nosebleeds ☐ Loss of smell ☐ Snoring ☐ Seasonal allergies

Throat & Voice ☐ Sore throat ☐ Hoarseness ☐ Trouble swallowing ☐ Heartburn / reflux ☐ Chronic cough

Head & Neck ☐ Neck lump ☐ Thyroid problem ☐ Facial pain ☐ Headaches

MEDICAL HISTORY

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Asthma ☐ Stroke ☐ Bleeding disorder ☐ Cancer ☐ Thyroid disease
☐ Sleep apnea ☐ Pregnant

Other conditions _____

Past surgeries (with dates) _____

MEDICATIONS & ALLERGIES

Current medications and doses _____

Blood thinners? ☐ No ☐ Yes (aspirin, Coumadin, Eliquis, etc.) | Which one(s)?

Drug allergies ☐ None known | Reaction

Other allergies (food, latex, environmental) | Reaction

Preferred pharmacy | Pharmacy phone / location

SOCIAL HISTORY

Tobacco: ☐ Never ☐ Former ☐ Current | Alcohol: ☐ No ☐ Yes | Occupation

Family history of hearing loss, ENT, or head & neck problems

ANYTHING ELSE WE SHOULD KNOW?

AUTHORIZATION

I certify that the information above is accurate to the best of my knowledge. I authorize Steve Y Kim, MD to provide treatment, to release information needed to process insurance claims, and to receive payment directly from my insurance carrier. I understand that I am financially responsible for any balance not covered by insurance.

Patient (or guardian) signature | Date

If signed by guardian, print name | Relationship to patient