Island ENT Wellness and Audiology
Medical and Surgical Expertise with a Holist Approach
420 Nokomis Avenue S, Venice FL 34285 call 941-786-0386 fax 941-761-6241
www.IslandENTVenice.com

Audiology Only Intake, if you are referred to Dr. Clark, you will be asked to complete our regular intake forms, please bring audiogram with you, in house audiograms available.

Name: ____ Birthdate ____/____/____
FL Address____
Email _______________________________________ Permission to text?_________
Landline __________________________ Cell ______________________________
Snowbird? Second address____

Primary Doctor __________________________ Pharmacy (where?)______________________________

Who can see your medical records? (relation)____

HT______________ Weight ______________ T_________ P________ BP ___________ O2_______%

Allergies to medications:
Medication, supplements, herbals dose (mg), how often taken
Permission to use a national database of pharmacies to access medication list? **Y / N**

Social history: (Circle). Never smoker, Ex Smoker. Smoker ___ cigs. per day
Alcohol: do not drink, former drinker, 0-4 glasses/month, 1-2/wk 1-2/day, 3 or more/day
Significant medical conditions and surgeries:

Are you having Dizziness? describe

Do you have hearing loss? Tinnitus? Ear pain? Which side? Trouble equalizing pressure in ears? Wax buildup? Last hearing test? Where?
Hearing Aids? Brand?
Do you wish they worked better?

Island ENT intake form Signature: ______________________________

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Consent to Treat and HIPAA Notice

Patient Name: ____

At Island ENT , it may be required for me to undergo physical examination or other diagnostic procedures and treatment that is deemed necessary by the treating doctor. The nature/need for the procedure will be explained prior and I am able to refuse any treatment or procedures. I consent to procedures deemed necessary, diagnostic study, disposal of bodily fluids/ tissue obtained with routine hospital/governmental regulation, prescription and/or administration of medication. All explanations of treatments/procedures/ medication administration will include intended purpose, reasonable foreseeable risks, consequences, benefits, and alternatives which may be used or performed in the course of diagnosing/treating. I understand that treatments/procedures/medication administration will not be exhaustive and that other risks or complications may arise, but the likelihood is not reasonable or foreseeable. I have been advised that if I would like a more detailed explanation prior to consent, that one will be given to me. I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result from examination(s), procedure(s), or treatment(s), which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I consent to photographing and/or videotaping the appropriate portions of my body, which are pertinent to showing my physical condition for medical, scientific, or education purposes provided reasonable precautions are taken to conceal my identity. I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make inquiries regarding any aspect of my diagnosis or treatment which I do not understand. By signing below, I represent to my doctor and this practice that I am eligible to give this consent.

Island ENT follows HIPAA guidelines in respect to Protected Health Information (PHI). Your PHI may be used or disclosed for the purpose of treatment, payment, or health care operations. Please see our Notice of Privacy Practices for an extensive overview of practices and patient's rights. Signing below also indicates that I received a notice of privacy practices and agree to allow this practice to use my health information as indicated above.

________________________________	________________________________
Patient or Representative Signature* Parent if under 18 years of age	Date
________________________________	________________________________
Relationship to Patient	Signature of Witness

*please notify us if your insurance changes and complete a new form.