USF DEPARTMENT OF OTOLARYNGOLOGY
EARS, NOSE & THROAT CENTER
Mailing: 12901 Bruce B. Downs Blvd., MDC 73
Tampa, Florida 33612
Phone: 813-974-4683 Fax: 813-974-7314

**ESTABLISHED PATIENT INFORMATION UPDATE** ***(RETURN VISIT)***

Patient Name:_____ Date:_____

Email: _____

**To keep your records up to date, check the box that indicates if any changes below apply to you.**

**Has your address changed since your last visit?** ☐ **Yes** ☐ **No**
If Yes, new address: _____
_____

**Has your phone number changed since your last visit?** ☐ **Yes** ☐ **No**
If Yes, new number(s): _____
_____

**Has you Primary Care Physician or Specialist changed since your last visit?** ☐ **Yes** ☐ **No**
If Yes, new physician / specialist: _____
_____

**Has your insurance changed since your last visit?** ☐ **Yes** ☐ **No**
If Yes, new insurance carrier and phone number. Make sure to notify the front desk: _____
_____

**Reason for Visit** *(Check One)* :

☐ Routine Follow-Up ☐ New Problem ☐ Post-Op Visit ☐ Self Referral ☐ Second Opinion
Explanation:_____

Check **YES** or **NO** to indicate any changes in your health since your last visit**:**

**Head & Neck Symptoms** ☐ **Yes** ☐ **No** If Yes, explain: _____

**X-Rays, CT / MRI / PET** ☐ **Yes** ☐ **No** If Yes, where: _____

**Blood Test** ☐ **Yes** ☐ **No** If Yes, where: _____

**General Medical condition** ☐ **Yes** ☐ **No** If Yes, explain: _____

**Surgery since last visit** ☐ **Yes** ☐ **No** If Yes, explain: _____

**Discontinued Medication** ☐ **Yes** ☐ **No** If Yes, name: _____

**Began New medication** ☐ **Yes** ☐ **No** If Yes, name: _____

* *ATTACH COPY OF INSURANCE CARD*

Reviewed By:

_____MD_____Date

_____LPN/RN/MA_____Date