PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:______________________REFERRED BY:____SEX:_________________

NAME:____BIRTHDATE:_______________________
LAST FIRST MIDDLE

MAILING ADDRESS:____
CITY STATE ZIP

TELEPHONE:_______________________CELL PHONE:______________________WORK NUMBER:____________________

SS #________________________MARITAL STATUS:__________EMAIL:____

EMPLOYER:______________________________________OCCUPATION:____

EMPLOYER'S ADDRESS:____

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RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:____

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NEXT OF KIN:____BIRTHDATE:_______________________

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________MALE________FEMALE_____________TELEPHONE:_______________________

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EMERGENCY CONTACT:____

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________MALE________FEMALE_____________TELEPHONE:_______________________

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RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:____RELATIONSHIP TO PATIENT:_______________________

ADDRESS:____
ADDRESS CITY STATE ZIP CODE

SS #:________________________BIRTHDATE_______________________________TELEPHONE:_______________________

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PRIMARY INSURANCE:____________________________ID#:_______________________GROUP#____________________

NAME OF INSURED:____INSURED'S BIRTHDATE:____________________

SECONDARY INSURANCE:_________________________ID#_______________________GROUP#____________________

NAME OF INSURED:____INSURED'S BIRTHDATE:____________________

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

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SIGNATURE:____DATE:____________________________

Tahlequah Medical Group- Ear Nose and Throat Clinic
Medical History

PATIENT NAME: ____ DOB: ___________ TODAY'S DATE: __________

REASON FOR TODAY'S VISIT____

PREVIOUS TREATMENT FOR THIS CONDITION____

PCP: ____ PHARMACY: ____

ALL SURGERIES	DATE OF SURGERY	DRUG ALLERGIES	NO KNOWN DRUG ALLERGIES

ALL MEDICAL PROBLEMS	CURRENT MEDICATIONS AND DOSES (INCLUDING OVER THE COUNTER)	

DO YOU TAKE ASPIRIN? Yes No
TOBACCO USE Yes How much daily?_____ How many years?______ No Quit _____ years ago
ALCOHOL USE Yes How much daily?_____ No CAFFEINE USE Yes How much?______________ No

FAMILY MEDICAL HISTORY
Mother: Alive Died age _____ Significant Medical Problems ____
Father: Alive Died age _____ Significant Medical Problems ____
Siblings: ____# sisters & ______# brothers Significant Medical Problems_____________________________________
Personal or family history of anesthesia problems? No Yes ____

Review of Systems. Please complete this section, check yes to symptoms that you have had in the past 3 months.

(Y) (N)
____ ____Changes in appetite/diet
____ ____Changes in weight
____ ____Fever
____ ____Fatigue
____ ____ Daytime sleepiness
____ ____Vision change
____ ____Eye discharge
____ ____ Hearing Concerns
____ ____ Ringing in ears
____ ____ Discharge from ears
____ ____ Nasal discharge
____ ____ Nosebleeds
____ ____ Nasal congestion
____ ____Dizziness
____ ____Depression
____ ____Anxiety

(Y) (N)
____ ____ Oral lesions/sores
____ ____Sore throat
____ ____Sore tongue
____ ____Cough
____ ____ Coughing up blood
____ ____Asthma
____ ____Snoring
____ ____ Chest pain
____ ____Palpitations
____ ____Headache
____ ____Seizures
____ ____Easy Bruising
____ ____Easy Bleeding
____ ____Swollen lymph nodes/glands
____ ____Atypical skin lesion(s)

(Y) (N)
____ ____Wheezing
____ ____ Shortness of breath
____ ____ Nausea
____ ____ Difficulty swallowing
____ ____ Reflux/Heartburn
____ ____ Vomiting
____ ____ Diarrhea
____ ____ Constipation
____ ____ Abdominal bloating
____ ____Headache
____ ____Allergies
____ ____Food allergies
____ ____Rashes
____ ____Itching
____ ____Hives