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:_____

****

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

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

RELIGION:_____

****

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:_____

****

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.

SIGNATURE:_____ DATE:_____

Tahlequah Medical Group- Ear Nose and Throat Clinic
Pediatric Medical History

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

REASON FOR TODAY'S VISIT_____

PREVIOUS TREATMENT FOR THIS CONDITION_____

WHO IS BRINGING CHILD IN TODAY? _____ RELATIONSHIP TO CHILD? _____

PCP:_____ PHARMACY:_____

ALL SURGERIES	DATE OF SURGERY	DRUG ALLERGIES	☐ NO KNOWN DRUG ALLERGIES

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

FULL TERM BIRTH ☐Yes ☐No Premature # of weeks ____ Pregnancy/birth complications _____
NEWBORN HEARING SCREEN ☐Passed ☐Failed VACCINATION up to date ☐Yes ☐ No
ATTENDS ☐Daycare ☐School ☐Home schooled EXPOSURE TO SECOND HAND SMOKE ☐Yes ☐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 Personal or family history of bleeding disorder? ☐No ☐Yes

Please complete the section that is age appropriate for your child.
Infants 0-12 months and Toddlers 1-3 years

(Y) (N)	(Y) (N)	(Y) (N)
____ ____Recent Fevers	____ ____Heart Murmur	____ ____Colic/Reflux
____ ____Change in Activity	____ ____Cardiac Problem	____ ____Vomiting
____ ____Weight Changes	____ ____Asthma	____ ____Diarrhea
____ ____Nasal Congestion	____ ____Snoring	____ ____Decreased Appetite
____ ____Runny Nose	____ ____Cough	____ ____Frequent UTIs
____ ____Mouth Breathing	____ ____Cyanosis (blue skin)	____ ____Yeast Infection
____ ____Oral Thrush (yeast)	____ ____Seizure Activity	____ ____Growth Disturbance
____ ____Hearing Concerns	____ ____Development Delay	____ ____Rashes
____ ____Speech Concerns	____ ____Easy Bruising	____ ____ Discoloration around eyes
____ ____Unusual Head Shape	____ ____Easy Bleeding	____ ____Eye discharge/Puffy eyes
	____ ____Blue skin with crying	

Pre-School 4-6 years, School Aged 7-13 years and Adolescent 14-17 years:

(Y) (N)	(Y) (N)	(Y) (N)
____ ____Recent Fevers	____ ____Snoring	____ ____Growth Disturbance
____ ____Change in Activity	____ ____Cough	____ ____Excessive Fatigue
____ ____Weight Difficulties	____ ____Witnessed Apnea	____ ____Limb Deformity
____ ____Nasal Congestion	____ ____Seizure Activity	____ ____Scoliosis
____ ____Sore Throat	____ ____Development Delay	____ ____Joint/Muscle Aches
____ ____Runny Nose	____ ____Easy Bruising	____ ____Rashes
____ ____Mouth Breathing	____ ____Easy Bleeding	____ ____Eczema
____ ____Hearing Concerns	____ ____Allergies Suspected	____ ____Eye discharge/Puffy eyes
____ ____Speech Concerns	____ ____Reflux	____ ____Discoloration around eyes
____ ____Headaches	____ ____Vomiting	____ ____Bed Wetting
____ ____Heart Murmur	____ ____Diarrhea	____ ____ADD/ADHD
____ ____Cardiac Problem	____ ____Asthma/RAD	____ ____Wheezing

Tahlequah Ear, Nose & Throat/ Allergy
1203 E. Ross Bypass
Tahlequah, OK 74464
P. 918-453-1234 / F. 918-453-9107

MEDICAL AUTHORIZATION FORM

I, _____, being the parent and/ or legal guardian of

_____ (hereinafter, "my child(ren)") do hereby authorize

_____ to seek and obtain medical care for my child(ren) in

the event that my child(ren) needs medical care.

My child has the following allergies: _____ (if applicable)

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this Authorization.

My health insurance carrier is _____
and my policy number is _____.

Effective Date _____, until January 1, 2018

Signature of Parent or (Legal Guardian) _____

Notary Signature_____