

**EAR, NOSE, THROAT GROUP, INC.
DRS. WRIGHT, FRANKLIN, RULEMAN & CHANDRA**

- 1.) Name and Address of Referring/Physician: _____
2.) Name and Address of Primary Care Doctor: _____

Please PRINT and complete this entire section. Answer all questions or we will be unable to file your insurance.

Which Doctor are you here to see: _____ Wright _____ Ruleman Today's Date _____
_____ Franklin _____ Chandra

PATIENT INFORMATION

PATIENT (last name) _____ (first/middle) _____
Street Address _____ City _____ State _____ Zip _____
Phone _____ Sex: M F Marital Status _____ Date of Birth ____ / ____ / ____
Age _____ Social Security # _____ Employer _____
Emp. Address _____ Phone _____
Spouse Name _____ Day Phone _____
If a child, give Mothers name _____ Fathers Name _____
Mother's Daytime Phone _____ Fathers Daytime Phone _____

RESPONSIBLE PARTY

Name _____ Relationship _____
Street Address _____ City _____ State _____ Zip _____
Phone _____ Social Security # _____ Date of Birth ____ / ____ / ____
Employer _____ Emp Phone _____
Emp Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Does your insurance require pre-certification? ____ Yes ____ No Second Surgical Opinion? ____ Yes ____ No
FIRST Insurance Name _____ Ins. Co. Phone _____
Address _____
Ins. Co. Phone _____ Policyholder _____ Relationship _____
Ins ID # _____ Group _____ Effective Date ____ / ____ / ____
Second Insurance Name _____ Ins. Co. Phone _____
Address _____
Ins. Co. Phone _____ Policyholder _____ Relationship _____
Ins ID # _____ Group _____ Effective Date ____ / ____ / ____

Is your condition due to an ACCIDENT ____ Yes ____ No Date of Accident ____ / ____ / ____
Please describe _____
Who should we contact to verify accident? Name _____ Phone _____

EMERGENCY Contact Name (other than spouse) _____ Phone _____
Secondary Contact Name _____ Phone _____

AUTHORIZATION

I authorize payment of any medical benefits to the physician member of the EAR, NOSE & THROAT GROUP, INC. for any services furnished me by those providers. I authorize the release of any medical records of related information. I understand the EAR, NOSE & THROAT GROUP, INC. will file my insurance for me if I am in a plan contracted with the GROUP. I further understand that I am financially responsible to the physician for all services rendered. I hereby authorize the doctor to complain to the insurance commission for any reason on my behalf.

Patient's Signature _____ Date _____

Have you ever had any of the following medical conditions (please circle)?

diabetes
reflux or stomach ulcer
stroke
asthma or emphysema
heart blood pressure
heart rhythm abnormality
cancer
psychiatric treatment
glaucoma/cataract

thyroid problem
hepatitis
seizure disorder
sleep apnea
heart attack/failure
heart valve problem/murmur
HIV/AIDS
meningitis
other _____

Could you be pregnant? No Yes

Please list all surgeries and hospitalizations with approximate dates:

_____	_____
_____	_____
_____	_____
_____	_____

Please list all medications including over-the-counter, vitamins/supplements, birth control pills, and inhalers.

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? No Yes (list) _____

have you been allergy tested? No Yes (list positives) _____

Have you ever smoked? No Yes _____ packs per day for _____ years
When did you quit? _____

Do you drink alcohol? No Yes _____ drinks per day

Do use recreational drugs? No Yes Inject drugs? No Yes

Occupation: _____

Family history of major medical problems (please circle):

a. cancer b. heart disease c. diabetes
d. asthma e. reaction to anesthesia f. other _____

Please circle if you have any of the following:

- | | | | |
|----------------------|---|---------------------|--|
| General: | fevers/chills/night sweats
unintended weight loss or gain
excess fatigue
sleep problems | Digestive: | nausea/vomiting
constipation
diarrhea
heart burn |
| Eyes: | itchy
excess tearing
change in vision
glasses | Urinary: | flank pain
pain on urination
abnormal urine
kidney stone |
| Ears: | hearing loss
ear pain/pressure/fullness
vertigo/imbalance
ringing/buzzing
discharge/drainage
hearing aid | Nervous: | headaches
numbness/tingling
paralysis/paresis
memory loss |
| Nose/sinus: | obstruction
runny/post nasal drip
facial pain or pressure
loss of smell or taste
foul odor
bleeding | Psychologic: | depression
anxiety |
| Mouth/throat: | sores/ulcers
dental problem/tooth pain
throat pain
difficulty swallowing
hoarseness | Heart: | chest pain
palpitations |
| Neck: | soreness/pain
lumps/swelling
stiffness
no problems | Lungs: | short of breath
wheezing
cough
previous TB
bronchitis |

Anything else you would like us to know?

All of the preceding information is correct to the best of my knowledge

(Signature)

Thank you. The rest is for your doctor.

Reviewing MD signature _____

HEALTH INFORMATION CONSENT

I understand that the Ear Nose & Throat Group, Inc. uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use and disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review the Ear Nose & Throat Group, Inc.'s Notice of Information Practices for more information about how my protected health information may be used and disclosed. I understand that the Ear Nose & Throat Group, Inc. may change its information practices, but before doing so, a new Notice will be posted in the waiting area and each examination room. I may also request a paper copy of the Notice.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information. The Ear Nose & Throat Group, Inc. is not required to agree to such restrictions, but if the Ear Nose & Throat Group, Inc. does agree, it must abide by those restrictions. I understand I have the right to revoke this consent, in writing, except where the Ear Nose & Throat Group, Inc. has already made disclosures in reliance of my prior consent.

You may discuss my health information with _____

You may not discuss my health information with _____

Name of Patient: _____ (PLEASE PRINT)

Signature of Patient or Legal
Representative: _____

If signed by someone other than patient, print name: _____

Relation to patient: _____