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____/____/____

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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______________

(Rev. 06/00)

EAR, NOSE & THROAT GROUP, INC.

PATIENT HISTORY FORM

IT IS IMPORTANT YOU ANSWER EVERY QUESTION

Leonard D. Wright, Jr., M. D., F.A.C.S.
Edgar R. Franklin, M. D., F.A.C.S.
C. Allan Ruleman, Jr., M. D., F.A.C.S.

NAME: ______________________ DATE: ______________________

CHIEF COMPLAINT? ______________________

DURATION OF SYMPTOMS: ______________________

NAME OF REFERRING DOCTOR: ______________________

REVIEW OF SYSTEMS: Do you **presently** have any of the following:

Yes	No		Yes	No	
☐	☐	Are you Pregnant?	☐	☐	Mitral Valve Prolapse
☐	☐	Decreased hearing	☐	☐	Heart Trouble
☐	☐	Ringing in Ear	☐	☐	Irregular Pulse
☐	☐	Ear Infections	☐	☐	Heartburn
☐	☐	Dizzy Spells	☐	☐	Difficulty Swallowing
☐	☐	Headaches (frequent)	☐	☐	Peptic Ulcer
☐	☐	Fainting Spells	☐	☐	Persistent Nausea
☐	☐	Loss of Vision	☐	☐	Jaundice/Hepatitis
☐	☐	Eye Pain	☐	☐	Chronic Fatigue
☐	☐	Nose Bleeds	☐	☐	Weight Loss (recent)
☐	☐	Sinus Trouble	☐	☐	Muscle Weakness
☐	☐	Sleep Apnea	☐	☐	Anemia
☐	☐	Sore Throats	☐	☐	Arthritis/Rheumatism
☐	☐	Hayfever/Allergies	☐	☐	Cancer
☐	☐	Hoarseness	☐	☐	Depression
☐	☐	Thyroid Disease	☐	☐	Diabetes
☐	☐	Pneumonia/Pleurisy	☐	☐	Stroke
☐	☐	Bronchitis/Chronic Cough	☐	☐	Urine Infections
☐	☐	Tuberculosis (previously)	☐	☐	High Cholesterol
☐	☐	Asthma/Wheezing	☐	☐	Allergy Previously Treated
☐	☐	Shortness of Breath	☐	☐	Excessive Noise Exposure
☐	☐	Chest Pain	☐	☐	Risk of/or Exposure to HIV
☐	☐	High Blood Pressure	☐	☐	Do you or anyone in your family have snoring problems?

THIS SECTION MUST BE COMPLETED

List all Medications you are currently taking:

Medication	Dosage	x's/day
Reason		
Medication	Dosage	x's/day
Reason		
Medication	Dosage	x's/day
Reason		
Medication	Dosage	x's/day
Reason		
Medication	Dosage	x's/day
Reason		

WHAT IS YOUR Height _____ Ft. _____ In. Weight _____ lbs.

ARE YOU ALLERGIC TO ANY DRUGS? ______ **NO** ______ **YES** **IF YES, LIST HERE:**

____

FAMILY HISTORY: Has any blood relative ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Hayfever	☐	☐	Alcoholism	☐	☐	Hypertension
☐	☐	High Cholesterol	☐	☐	Diabetes	☐	☐	Hearing Loss
☐	☐	Migraine	☐	☐	Stroke	☐	☐	Heart Disease
☐	☐	Asthma	☐	☐	Cancer	☐	☐	Bleeds Easily

SOCIAL HISTORY:

Marital Status __M__S __D __W Occupation __________________ How Much? Coffee/Tea _____ cups/day

Cigarettes, Chewing Tobacco, Cigars, Pipes _____ per day for _____ years. Alcohol _____ per day

PAST HISTORY : LIST ALL HOSPITAL ADMISSIONS:

Illness or Operation ______________________ When ____________

Illness or Operation ______________________ When ____________

Illness or Operation ______________________ When ____________

Patient Signature ______________________ **Date** ____________

Reviewed By Physician _______
(Initials)

Rev 2/01

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:____________________