

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

Name and Address of your Referring Physician: _____

Please PRINT and complete this entire section. Answer all questions and please be accurate.

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

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 _____

If a child, give Mothers name _____ Fathers name _____

Mother's Daytime Phone _____ Father's 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

Please complete each line below and list if you have Medicare or Medicaid. Be sure to give us your insurance cards.

Does your insurance require pre-certification ___ Yes ___ No Second Surgical Opinion? ___ Yes ___ No

FIRST Insurance Name

Address _____

Ins. Co. Phone _____ Policyholder _____ Relationship _____

Ins ID# _____ Group # _____ Effective Date ___/___/___

SECOND Insurance Name

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 _____ Phone _____

Secondary Contact Name _____ Phone _____

AUTHORIZATION

I authorize payment of any medical benefits to the physician members of the EAR, NOSE & THROAT GROUP, INC for any services furnished me by those providers I authorize the release of any medical records or related information understand the EAR, NOSE, & THROAT GROUP, INC will flue 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.

Patient's Signature _____ Date _____

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.
 RANDOLPH M. RICHARDS, M.D.

NAME: _____ DATE: _____

CHIEF COMPLAINT? _____

DURATION OF SYMPTOMS: _____

NAME OF REFERRING DOCTOR: _____

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

List all medications you are currently taking:

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

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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hayfever | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Bleeds Easily |

SOCIAL HISTORY:

Marital Status: ___M___S___D___W Occupation _____
 Cigarettes, Chewing Tobacco, Cigars, Pipes _____ per day for _____ years.

How Much? Coffee/Tea _____ cups/day
 Alcohol _____ per day

PAST HISTORY: LIST ALL HOSPITAL ADMISSIONS OR SURGERIES:

Illness or Operation _____	When _____
Illness or Operation _____	When _____
Illness or Operation _____	When _____
Patient Signature _____	Date _____

Reviewed By Physician _____
 (Initials)