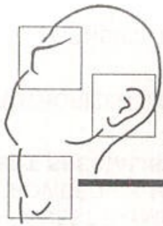

Ear, Nose & Throat Specialists of Abilene

1233 N. 18th • Abilene, Texas 79601 • Phone (325) 437-3687 • FAX (325) 437-3618

NAME: ______________________ D.O.B.: ____________ AGE: ______ SEX: ______

REFERRING PHYSICIAN: ______________________ FAMILY PHYSICIAN: ______________________

DESCRIBE THE CURRENT MEDICAL PROBLEM FOR TODAY'S VISIT: ______________________

____

ALLERGIES TO MEDICATIONS: ______________________

ALLERGIES TO SPECIFIC BRANDS OF SOAPS / LAUNDRY DETERGENTS / FOOD: ______________________

OTHER PHYSICIANS TREATING YOU: ______________________

FEMALES: ARE YOU CURRENTLY PREGNANT, PLANNING PREGNANCY OR NURSING A CHILD? ☐ YES ☐ NO

DO YOU OR HAVE YOU USED TOBACCO PRODUCTS? ☐ YES ☐ NO # OF YEARS: ______ HOW MUCH? ______

☐ CIGARETTES ☐ PIPE ☐ CIGARS ☐ CHEWING TOBACCO INTERESTED IN STOPPING? ☐ YES ☐ NO

DO YOU REGULARLY DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY OUNCES/BEERS PER DAY? ______

DO YOU REGULARLY DRINK COFFEE? ☐ YES ☐ NO HOW MANY CUPS PER DAY? ______

ARE YOU UNDER A LOT OF PRESSURE AT WORK? ☐ YES ☐ NO PLEASE DESCRIBE: ______________________

PERSONAL MEDICAL HISTORY

HEIGHT: ______FT. ______IN. WEIGHT: __________LBS.

PREVIOUS OR OTHER MEDICAL PROBLEMS: ______________________

PAST SURGERIES OR HOSPITALIZATIONS: ______________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)?

- ☐ ALLERGIES / ECZEMA
- ☐ HEADACHES
- ☐ CHEST PAIN / PRESSURE
- ☐ EAR INFECTIONS / DRAINAGE
- ☐ ULCERS / REFLUX
- ☐ TB / LUNG DISORDERS
- ☐ VERTIGO
- ☐ ABNORMAL LUMP / LYMPH NODE
- ☐ SINUS / NASAL SURGERY
- ☐ HEART ATTACK / HEART DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ HEAD TRAUMA
- ☐ ARTHRITIS / JOINT PAIN
- ☐ DIZZY SPELLS / WEAKNESS
- ☐ THYROID DISORDERS
- ☐ CANCER OF ANY TYPE / RADIATION
- ☐ HIGH BLOOD PRESSURE / STROKE
- ☐ ASTHMA
- ☐ MEMORY LOSS
- ☐ DIABETES
- ☐ DIFFICULTY OR LOSS OF HEARING
- ☐ COUGHING UP BLOOD
- ☐ HIV / AIDS
- ☐ SKIN DISORDERS
- ☐ SEIZURES / EPILEPSY
- ☐ BLEEDING TENDENCY
- ☐ RINGING IN EARS
- ☐ HOARSENESS / VOICE CHANGES
- ☐ HEPATITIS
- ☐ UNCOORDINATED MOVEMENT

FAMILY HEALTH HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
ECZEMA / PSORIASIS	☐	☐	☐	☐	☐	☐
HEART ATTACK / STROKE	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐
HAY FEVER	☐	☐	☐	☐	☐	☐

SIGNATURE: ______________________ DR. ______________________ IN OFFICE

Jeffrey M. Braaten, D.O. • Gary D. Goodnight, D.O. • Theodore C. Dyer, M.D. • Paula Parkhill, FNP-C

PAPER TIGER PRINTING • ABILENE, TEXAS

TODAY'S DATE: ____________________

PATIENT'S NAME: ____________________ D.O.B.: ____________ AGE: ________ SEX: ________

SOCIAL SECURITY #: ____________________

NAME OF PARENT OR GUARDIAN (IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): ____________________

NAME OF PERSON(S) RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT): ____________________

MAILING ADDRESS: ____________________ APT.: ________

CITY, STATE, ZIP: ____________________ HOME PHONE: ( ) ____________

BUSINESS PHONE: ( ) ____________ EMPLOYER: ____________________

BUSINESS ADDRESS: ____________________

BUSINESS PHONE PARENT / SPOUSE: ( ) ____________ EMPLOYER: ____________________

BUSINESS ADDRESS: ____________________

FINANCIALLY RESPONSIBLE PERSON'S:

DRIVER'S LICENSE #: ____________ STATE: ________ WE WILL ASK TO MAKE A COPY OF YOUR LICENSE

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? ☐ YES ☐ NO

MAY WE LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? ☐ YES ☐ NO

PLEASE LIST PERSONS WITH WHOM WE CAN DISCUSS YOUR MEDICAL INFORMATION:

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

EMERGENCY CONTACT: ____________________ RELATIONSHIP: ____________

HOME PHONE: ( ) ____________ BUSINESS PHONE: ( ) ____________

INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARDS

PRIMARY INSURANCE COMPANY NAME: ____________________

POLICY HOLDER'S NAME: ____________________ DATE OF BIRTH: ____________

POLICY #: ____________ GROUP #: ____________ SOCIAL SECURITY #: ____________

SECONDARY INSURANCE COMPANY NAME: ____________________

POLICY HOLDER'S NAME: ____________________ DATE OF BIRTH: ____________

POLICY #: ____________ GROUP #: ____________ SOCIAL SECURITY #: ____________

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO REFERRING DOCTOR AND/OR ANY DOCTOR TO WHOM DRS. BRAATEN, DYER, OR GOODNIGHT MAY REFER ME. I AUTHORIZE MY FAMILY OR REFERRING DOCTOR TO RELEASE MY RECORDS TO DRS. BRAATEN, DYER, OR GOODNIGHT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENTS OF INSURANCE BENEFITS BE MADE TO **ENT SPECIALISTS OF ABILENE**. I HEREBY AFFIRM THAT ALL INFORMATION PROVIDED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND WILL ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT WITH **ENT SPECIALISTS OF ABILENE.**

AUTHORIZED SIGNATURE: ____________________ S.S. #: ____________ B.D.: ____________

RELATIONSHIP TO PATIENT: ____________________

PAPER TIGER PRINTING • ABILENE, TEXAS