WELCOME TO ALAMANCE EAR, NOSE & THROAT, LLP

PATIENT NAME: _____ SS#: _____
FIRST MI LAST

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ BIRTHDATE: _____ AGE: _____ M:___ F:___ MARITAL STATUS: S__ M__ W__ D__

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

EMAIL: _____ PREFERRED LANGUAGE: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ ST: ____ ZIP: _____

IN CASE OF EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE: (HOME) _____ **(CELL)** _____ **(WORK)** _____

PREFERRED PHARMACY: _____ PHONE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN _____

FAMILY, GUARDIAN AND/OR AUTHORIZED PERSON(S) WHO MAY HAVE ACCESS TO YOUR PERSONAL HEALTH INFORMATION (PHI) OR ALAMANCE ENT STAFF CAN SPEAK WITH REGARDING YOUR CARE

NAME	RELATIONSHIP	PHONE #

COMPLETE THIS SECTION ONLY IF YOU ARE MARRIED:

NAME OF SPOUSE: _____ BIRTHDATE: _____ AGE: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER'S PHONE: _____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE:

RESPONSIBLE PARTY: _____ BIRTHDATE: _____ AGE: _____ OCCUPATION: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PLEASE INITIAL EACH LINE BELOW AND SIGN AT THE BOTTOM OF THE PAGE:

____ I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM.

____ I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS TO ALAMANCE EAR, NOSE & THROAT, LLP

____ I ACKNOWLEDGE I HAVE RECEIVED A COPY OF ALAMANCE EAR, NOSE & THROAT LLP'S HIPAA POLICY

____ I ACKNOWLEDGE THAT ALAMANCE EAR, NOSE & THROAT, LLP WILL FILE INSURANCE FOR ALL REIMBURSABLE SERVICES, TO BOTH MY PRIMARY AND SECONDARY INSURANCE CARRIERS. **I AM RESPONSIBLE FOR ALL DEDUCTIBLE, COPAY, CO-INSURANCE AND NON-COVERED SERVICE AMOUNTS. IF I AM SEEN WITHOUT THE PROPER REFERRAL OR PRIOR AUTHORIZATION FORM FROM MY PCP, I WILL BE RESPONSIBLE FOR CHARGES INCURRED FOR THAT VISIT AND SERVICES.**

SIGNATURE OF PATIENT OR RESONSIBLE PARTY: _____ DATE: _____

Alamance Ear, Nose & Throat, LLP

PAUL H. JUENGEL, M.D.
CHAPMAN T. MCQUEEN, M.D.
P. SCOTT BENNETT, M.D.
CREIGHTON C. VAUGHT, M.D.

For Office Use Only

Patient Name: _____
MR#: _____ **Sex: M F**
Date of Birth: _____ **Age:** _____
Date of Visit: _____

WHO IS YOUR REGULAR PHYSICIAN? _____ **WHO REFERRED YOU HERE?** _____

WHAT IS THE MAIN PROBLEM OR SYMPTOM THAT BRINGS YOU HERE? _____

PAST MEDICAL HISTORY AND FAMILY HISTORY

PLEASE CIRCLE YES (Y) OR NO (N) FOR YOURSELF AND FAMILY. USE EXTRA SPACE BESIDE ANSWER, IF NEEDED, TO EXPLAIN, OR TO INDICATE WHICH FAMILY MEMBERS ARE AFFECTED.

Disease	Patient	Family Who is affected?	Disease	Patient	Family Who is affected?
Alcoholism	Y N	Y N	High Cholesterol	Y N	Y N
Anemia	Y N	Y N	High Blood Pressure	Y N	Y N
Arthritis	Y N	Y N	Kidney Disease	Y N	Y N
Asthma	Y N	Y N	Mental Illness	Y N	Y N
Bleeds Easily	Y N	Y N	Obesity	Y N	Y N
Cancer (type)	Y N	Y N	Osteoporosis	Y N	Y N
Diabetes	Y N	Y N	Stomach Ulcers	Y N	Y N
Epilepsy	Y N	Y N	Stroke	Y N	Y N
Glaucoma	Y N	Y N	Sexually Transmitted	Y N	Y N
Heart Disease	Y N	Y N	Disease (please specify)		
Hepatitis	Y N	Y N	Thyroid Disease	Y N	Y N
HIV or AIDS	Y N	Y N	Tuberculosis	Y N	Y N

Drug Allergies and type of reaction: _____

Medications and doses: _____

Other Medical History: _____

Past Surgeries: _____

Prior Allergy Testing: _____

PATIENTS: PLEASE CONTINUE ON BACK OF PAGE

Social History: Occupation: _____ Marital Status: _____ Children: _____
Current Smoker: Y N Past Smoker: Y N Date Quit: _____ Packs per day: _____ Years Smoked: _____
Snuff/Chewing Tobacco: _____ Other Recreational Drug Use: _____
Alcohol Use: Y N Number of Drinks Per Day of Beer: _____ Wine: _____ Liquor: _____
If patient is a child:
Are there smokers in the household? Y N
Where does the child stay during the day? ___ At Home ___ In preschool/ daycare ___ School Other:_____

Review of Systems: Are you currently having any of the following

Dizziness:	Y N	Weight Change:	Y N	Joint Pain:	Y N
Hearing Change:	Y N	Anxiety:	Y N	Headache:	Y N
Ringing in Ears:	Y N	Depression:	Y N	Urinary problems:	Y N
Fever:	Y N	Night Sweats:	Y N	Difficulty Swallowing:	Y N
Rash:	Y N	Cough:	Y N	Shortness of Breath:	Y N
Chest Pain:	Y N	Heartburn/ Indigestion:	Y N	Vision Change:	Y N
Nausea/Vomiting:	Y N	Easy Bleeding:	Y N		

Weakness/Numbness in arms/legs: Y N Heat/Cold intolerance: Y N

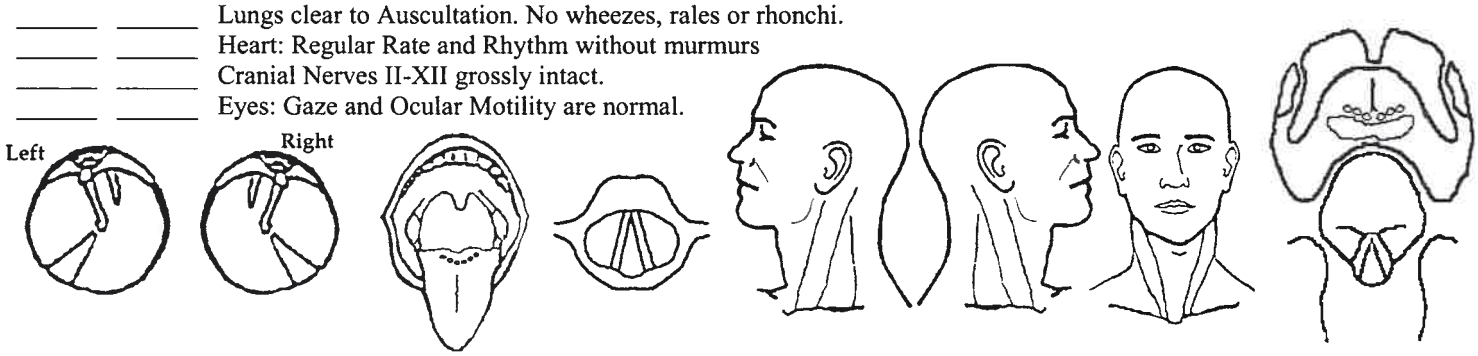
If any of the above symptoms are not directly related to the problem for which we are now seeing you, you are encouraged to follow up with your primary care physician for further evaluation.

*******DO NOT WRITE BELOW. FOR PHYSICIAN USE ONLY.*******

Physical Exam: Vital Signs: Ht_____ Wt_____ Pulse_____ BP_____/_____ Temp_____

Normal Abnormal (if marked abnormal, findings are dictated)

_____ _____ General: Well-developed, Well-nourished in no acute distress
_____ _____ Vocal Quality: no hoarseness or stridor
_____ _____ Head/Face: NCAT. Symmetric facial features. No significant skin lesions or scars
_____ _____ Face: no tenderness with sinus percussion
_____ _____ Facial Strength normal and symmetric
_____ _____ External Ears without lesions or deformity. Ear canals free of cerumen or infection. Tympanic membranes intact with no infection, good landmarks and normal light reflex. Normal mobility by pneumatic otoscopy.
_____ _____ Weber and Rinne exams normal. Grossly normal hearing.
_____ _____ External Nose dorsum essentially midline with no skin lesions
_____ _____ Nasal Septum essentially straight. Mucosa without congestion or Erythema. Turbinates normal. No polyps.
_____ _____ Lips and gums without lesions. No dental caries.
_____ _____ Oropharynx: Tongue, floor of mouth and buccal mucosa without lesions. Palate and uvula without lesions. No tonsillar hypertrophy or exudates. Posterior pharynx without lesions or exudates.
_____ _____ Larynx: tongue base, epiglottis, vocal cords without lesions, Erythema or exudates. Normal vocal cord motion
_____ _____ Hypopharynx/Piriform Sinuses: Clear, no pooling of secretions or visible lesions.
_____ _____ Nasopharynx free of visible lesions by indirect exam.
_____ UNABLE TO EXAMINE LARYNX, HYPOPHARYNX OR NASOPHARYNX DUE TO GAG REFLEX
_____ _____ Neck Supple, symmetric without masses or skin lesions. Trachea midline.
_____ _____ Thyroid symmetric without palpable masses or nodules or tenderness. No thyromegaly.
_____ _____ Parotid and submandibular glands are symmetric with no tenderness or masses or palpable stones.
_____ _____ Cervical lymph nodes are without palpable lymphadenopathy or tenderness.
_____ _____ Lungs clear to Auscultation. No wheezes, rales or rhonchi.
_____ _____ Heart: Regular Rate and Rhythm without murmurs
_____ _____ Cranial Nerves II-XII grossly intact.
_____ _____ Eyes: Gaze and Ocular Motility are normal.



Assessment: _____

Plan: _____

___ New Pt ___ Consult ___ Est Pt Level: 1 2 3 4 5 Physician Signature: _____