Dr. Brad Millman, M.D.

PATIENT INFORMATION SHEET

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SS# _____ DOB _____ AGE _____ SEX ____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

EMERGENCY CONTACT _____ RELATION _____ PHONE # _____

REFERRING PHYSICIAN _____ PHONE _____

PHARMACY NAME _____ PHONE # _____

EMPLOYER _____

EMPLOYER ADDRESS _____

PRIMARY INSURANCE

Policy Holder _____ Relationship _____

DOB _____ SS# _____ Sex Male/Female (circle one)

Insurance Company Name _____ Effective Date _____

ID # _____ Group # _____ Co Pay _____

Insurance Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Policy Holder Name _____ DOB _____ SS# _____

Insurance Company Name _____ Effective Date _____

ID# _____ Group # _____ Co Pay _____

Insurance Address _____ City _____ State _____ Zip _____

WORKMAN COMPENSATION / MOTOR VECHILE

Company Name _____ Date of Injury _____

Address _____ City _____ State _____ Zip _____

Adjuster Name _____ Phone # _____

Claim # _____ Fax # _____

MEDICAL HISTORY FORM

Name _____ Date _____

** REASON FOR TODAY'S VISIT ** _____

MEDICAL HISTORY

- Heart Attack
- Date _____
- Heart Disease
- Heart Surgery
- High Blood Pressure
- Elevated Cholesterol
- Poor Circulation

- Stroke Date _____
- Parkinson's Disease
- Tremor
- Weakness

- Respiratory Disease
- Asthma
- Chronic Bronchitis

- Emphysema
- Sarcoidosis

- Psychiatric Illness
- Depression

- Cancer
  - Lung
  - Breast
  - Lymphoma
  - Bone
  - Leukemia
  - Other _____
- Allergies
  - Hay Fever
  - Foods
  - Other _____
- Skin Disease
  - Psoriasis
  - Dermatitis
  - Hives

- Vision Problems
  - Cataract
  - Macular Degeneration
  - Glaucoma

- Diabetes
  - Insulin
- Thyroid Disease
- Thyroid Surgery
  - Date _____
- Renal failure
  - Dialysis
  - Date Began _____
- HIV

Other Problems: _____

SURGERY

- Adeniodectomy
- Appendectomy
- Back
- Brain
- Breast
- Carpal Tunnel
- Ear
- Gall Bladder
- Hernia
- Hysterectomy
- Joint Replacement
- Joint Scope
- Mastoidectomy
- Septoplasty
- Sinus Surgery
- Tonsillectomy

Other _____

SYMPTOMS

- Nasal Pain
- Congestion
- Nasal Drainage
- Sneezing
- Facial Pain
- Nose Bleeds

- Hearing Loss
- Ringing in Ears
- Ear Drainage
- Ear Pressure
- Dizziness

- Arm/Leg Pain
- Arm/Leg Weakness
- Slurred Speech
- Facial Weakness
- Facial Swelling
- Cough

- Weight Loss
- Fatigue
- Night Sweats
- Nausea
- Vomiting

- Headaches
- Sore Throat
- Difficulty Swallowing
- Heartburn
- Hoarseness
- Dry Mouth

- Blurred Vision
- Double Vision

- Sleep Trouble
- Snoring

- Chest Pain
- Wheeze

- Neck Pain
- Neck Swelling
- Neck Stiffness

- Other _____

Tobacco _____packs per Day Beer/Alcohol _____ amount per Day Caffeine _____ cups per Day

DRUG ALLERGIES

- NKDA
- Penicillin (Keflex, Amoxicillin)
- Erythromycin
- Sulfa

Other _____

MEDICATIONS

Heart _____
Blood Pressure _____
Diabetes _____
Asthma _____
Reflux _____
Allergies _____
Arthritis _____
Other _____

Ears, Nose, Throat & Allergy Associates, a division of Pinnacle Physicians Group

Treatment authorization and terms of treatment agreement.

A. **Consent for treatment:** I understand that treatment in this office is initiated because of my condition. I voluntary authorize and consent to the usual and customary examinations, tests, procedures and customary medical treatments as ordered by a physician or other independent licensed practitioner.

B. **Patient's Certification and payment requested:** I hereby authorize payment of any and all office insurance benefits otherwise payable to me, directly to Ear, Nose, Throat & Allergy Associates, a division of Pinnacle Physicians Group and/or those physicians who participate in my care. I understand that I am financially responsible for all charges not covered by my insurance. I assign the benefits payable for Ear, Nose, Throat & Allergy Associates, a division of Pinnacle Physicians Group or physicians furnishing the services and I authorize Ear, Nose, Throat & Allergy Associates, a division of Pinnacle Physicians Group and/or physicians to submit a claim for payment to Medicare or other insurance companies. I certify that the information given by me, if applying for payment under Title XVIII of the Social Security Act (Medicare), is correct.

C. **ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES.** I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

I certify that my name, as given below, is correct and that I am the person named.

PRINT – Patient Name _____ **Patient Signature** _____ **Date** _____

PRINT – Parent or Guardian Name _____ **Parent or Guardian Signature** _____ **Relation to Patient** _____

D. **Patient rights (All Patient):** I acknowledge that I am aware of the Patient Rights and Responsibilities that such information is available at the point of registration.

Patient Initials _____

E. **Acknowledgement of receipt of notice of Privacy Practices:** I acknowledge that I have been offered or have received a copy of the Notice of Privacy Practices of Ears, Nose, Throat & Allergy Associates, a division of Pinnacle Group for me or the patient above.

Print-Patient or Personal Representative Name _____ **Signature- Patient or Personal Representative** _____ **Relation** _____ **Date**

A good faith attempt to obtain the above acknowledge offer or receipt of Notice of Privacy Practices was made, but was not successful for the following reason(s): patient/ personal representative refused or was unable to sign, other (specify):_____

Print- Name _____ **Signature** _____ **Job Title** _____ **Date** _____

I herby give_____ _____ my permission to have access to my medical information.
Name **Relation**

_____ _____
Patient Signature **Date**