

In order to serve you properly we require the following information. All information provided will be strictly confidential. (PLEASE PRINT)

REFERRAL SOURCE: PHYSICIAN _____ YELLOW PAGES INTERNET
 FRIEND _____ NEWSPAPER OTHER _____

1 - PATIENT INFORMATION: Adult or Child Female Male

Name _____ Birth Date ____/____/____
Last First MI (Nickname) M D Y

SSN# - - Driver's License # _____ Marital Status S M D W **PHONE NUMBERS**

Mailing _____ Home _____
Address Street/PO Box Apt/Sp City State Zip

Physical _____ Work _____
Address (If different from mailing address) Street Apt/Sp City State Zip

Employer _____ Occupation _____ Cell _____

Employer _____ EMAIL: _____
Address Street/PO Box Suite City State Zip

2 - SPOUSE or PARENT ACCOMPANYING A CHILD: **PHONE NUMBERS**

Name _____ Address _____ Home _____
Last First MI

SSN# - - Driver's License # _____ Birth Date ____/____/____
M D Y Work _____

Employer _____ Occupation _____ Cell _____

3 - CONTACT INFORMATION: (With whom may we discuss your medical record or account?)

Medical: Name _____ Relation _____ Phone Number _____

Financial: Name _____ Relation _____ Phone Number _____

Emergency: Name _____ Relation _____ Phone Number _____

4 - PRIMARY INSURANCE: Benefits Phone _____

Ins. Co. _____ Address _____
Name Street/PO Box Suite City State Zip

Insured's _____ Relationship _____ Insured's ____/____/____
Name Last First MI to Patient Birth Date M D Y

Insured's SS# _____ Ins. ID # _____ Group/Plan/Local # _____

5 - SECONDARY INSURANCE: Benefits Phone _____

Ins. Co. _____ Address _____
Name Street/PO Box Suite City State Zip

Insured's _____ Relationship _____ Insured's ____/____/____
Name Last First MI to Patient Birth Date M D Y

Insured's SS# _____ Ins. ID # _____ Group/Plan/Local # _____

I AUTHORIZE MY INSURANCE COMPANY TO ISSUE THE MEDICAL BENEFITS OF MY PLAN DIRECTLY TO DRs. ELLERBE AND KALLMAN, INC. FOR SERVICES RENDERED TO ME. I UNDERSTAND AND AGREE, THAT IF INSURANCE DOES NOT COVER SERVICES, OR IF THE PHYSICIAN DOES NOT ACCEPT ASSIGNMENT, I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES. I ALSO AUTHORIZE THE RELEASE TO MY INSURANCE COMPANY OF INFORMATION REGARDING MY TREATMENT OR THE DIAGNOSIS OF MY CONDITION THAT WILL AID IN PAYMENT.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ PRINT NAME _____

RELATIONSHIP TO PATIENT: Self Mother Father Stepparent Other _____ DATE _____

The Alaska Center for Otolaryngology and Facial Plastic Surgery
Dwight M. Ellerbe, M.D. James E. Kallman, M.D. Stephan B. Schaffer, M.D.

NAME _____

DATE _____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

ARE YOU OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (check all that apply)

- Hypertension
- Heart Attack
- Stroke
- Other Heart Problems

- Diabetes
- Thyroid Problems

- Bleeding Disorder
- Blood Clots

- Depression
- Anxiety

- Asthma
- Other Lung Problems

- Skin Problems
- Skin Cancer
- Other Cancer

- Kidney Problems

- Allergies/Hayfever

- HIV
- Hepatitis

- Stomach Problems
- Other _____

PAST SURGERIES (list surgery and approximate date)

ALLERGIES TO MEDICATIONS (list medication, reaction)

CURRENT MEDICATIONS (prescription, herbal, OTC meds)

PRIMARY PHYSICIAN _____

PHARMACY _____

FAMILY HISTORY (check all that apply)

- Hearing Loss
- Allergies
- Asthma
- Cancer
- Thyroid Disease
- Other Health Problems (list)

SOCIAL HISTORY

Have you ever used tobacco? yes no quit date _____
Amount: _____ packs/day for _____ years
Type: _____ cigarettes _____ chewing tobacco

Do you drink alcohol? yes no
Amount: _____ drinks per day/week/month

Do you drink caffeinated beverages? yes no
Amount: _____ cups or cans per day
Type: coffee soda tea

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (check all conditions that apply)

Constitutional

- fever
- pain
- weight loss/gain

Neurological

- headaches
- weakness
- numbness

Eyes

- itching dryness
- excessive tearing

Ears, Nose, Mouth, Throat

- hearing loss
- nasal obstruction
- runny nose
- nosebleeds
- snoring
- sore throat
- lump in neck

Cardiovascular

- chest pain
- shortness of breath
- palpitations

Respiratory

- cough
- hoarseness
- wheezing
- noisy breathing

Gastrointestinal

- heartburn
- throat clearing

Musculoskeletal

- muscle pain
- joint pain

Skin

- rash
- acne
- change in moles

Endocrine

- cold/heat intolerance
- night sweats

Allergic/Immunologic

- sneezing
- frequent infections