QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number** | **Gender** ___Male ___Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed | **Language** other than English

Race ☐ Black ☐American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White – ☐Other Non Hispanic

Mailing Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Cell Phone**

Email Address | **Employment Status** ☐ Employed ☐ Not Employed ☐ Student ☐ Child ☐ Retired ☐ Self Employed ☐ Other

Employer | **Employer Phone**

Preferred Method of Appointment Reminder ☐ Call ☐ Text ☐ Email

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐Self (If self, skip to Emergency / Next of Kin) ☐Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Cell Phone | **Work Phone**

Employer | **Employment Status** ☐ Employed ☐ Not Employed ☐ Student ☐ Retired ☐ Self Employed ☐ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Phone | **Cell Phone**

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

Insurance Information

Primary Insurance _____

ID# _____Group#_____

Cardholders Name _____Dob _____

SSN_____

Relation to Patient _____

Secondary Insurance _____

ID# _____Group#_____

Cardholders Name _____Dob _____

SSN_____

Relation to Patient _____

Tertiary Insurance _____

ID# _____Group#_____

Cardholders Name _____Dob _____

SSN_____

Relation to Patient _____

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

Notice of Privacy Practice

I have been informed that Quail Creek Ear, Nose and Throat Center has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

_____ _____

Signature Date

_____ _____

Print Name Relation to Patient

I authorize that my medical information can be released to:

_____	_____
Name	Name
_____	_____
Relation to Patient	Relation to Patient
_____	_____
Patient Signature	Patient Signature
_____	_____
Date	Date

_____	_____
Name	Name
_____	_____
Relation to Patient	Relation to Patient
_____	_____
Patient Signature	Patient Signature
_____	_____
Date	Date

_____ I understand that no information, including appointment information, will be released to anyone not listed on this form.

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

Patient Consent

- I consent to treatment necessary for the care of named patient.
- I acknowledge full financial responsibility for services rendered by Quail Creek Ear, Nose and Throat Center.
- I understand that payment of charges is due at the time of service unless other arrangements have been made prior to treatment.
- I authorize release of information to my insurance company in order to process claims and authorize payment to be made to Quail Creek Ear, Nose and Throat Center.
- I authorize release of my medial information to any other facility that I am referred to by this office.
- I authorize the use of my photo as part of my permanent medical record

I have read and understand the Patient Consent and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party for Minor Date

_____

Print Name of Patient

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advanced by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept, Cash, Check, Visa, MasterCard, Discover and Care Credit.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment/coinsurance/deductible at the time of service. This office's policy is to collect this copayment/coinsurance/deductible when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at time of service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

No Insurance- Self Pay Discount

- Offer discounted rate for prompt payment.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party of Minor Date

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

HISTORY

CHIEF COMPLAINT: (Main reason for today's visit)

_____

MEDICAL ILLNESSES: Circle any of the following you are currently being treated for:

Asthma Cancer Diabetes Emphysema Heart Disease High Blood Pressure Seizures Stroke

Other:

_____

_____

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

_____

_____

CURRENT MEDICATIONS: List all of your medications prescribed and over the counter. Include dose and directions:

_____

_____

_____

_____

_____

DRUG ALLERGIES: List all medications you are allergic to and the type of reaction:

_____

_____

PREFERRED PHARMACY:

_____

Do you consent to the use of blood or blood products? ___ Yes ___No

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

FAMILY HISTORY

Father Medical Illnesses:

_____

_____

Mother Medical Illnesses:

_____

_____

Brothers/Sisters Medical Illnesses:

_____

_____

Other Relatives Medical Illnesses:

_____

_____

Do you or anyone in your family have Asthma? ___Yes ___No

Do you or anyone in your family have problems with Anesthesia? ____Yes ____No (if Yes please explain)

_____

Do you or anyone in your family have a bleeding disorder? ____Yes ____No (if Yes please explain)

_____

PREVENTATIVE CARE (18 and older only)

Do you currently use tobacco products: Yes_____ No_____ If yes, what type of tobacco?

Cigarettes _____ Cigars _____ Chewing tobacco/ Snuff _____ Other _____

If no, did you ever: Yes _____ No _____

When did you stop: _____

Do you drink alcohol: Yes _____ No _____

What type and how much? _____

Do you use recreational drugs: Yes _____ No _____

What type and how much? _____

How many children do you have? _____

Occupation:_____

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

REVIEW OF SYMPTOMS

Please circle any of the following symptoms that you have experienced in the recent past or in connection with your current ear, nose or throat problem (s). If none apply write NONE:

Ears:	Ear Pain	Ear Drainage	Dizziness	Change in hearing	Imbalance
	Chronic Ear Canal Infection	Ringing/ Head noise	Ear infection	Hearing loss	
Nose:	Runny Nose	Stuffiness	Bloody Nose	Nasal Obstruction	Sinusitis
	Altered Sense of smell				
Throat:	Hoarseness	Post Nasal Drainage	Difficulty Swallowing	Recurrent Infection	Snoring
	Voice changes/ Problems	Sore Throat			
Allergy:	Hives	Post Nasal Drainage	Nasal Congestion	Itchy Nose	Itchy Eyes
	Excessive Fatigue	Chronic cough	Dry cough	Loss of smell	Itchy Ears
	Throat Irritation	Headaches	Sneezing		
Respiratory:	Coughing up Blood	Pain with Breathing	Shortness of Breath	Wheezing	Productive Cough
Cardiac:	Chest Pain	Rapid/ Irregular Heartbeat			
Gastro:	Appetite/Weight Change	Blood in Stool	Bowel Problem	Canker Sores	Diarrhea
	Heartburn/ Indigestion				
Constitutional:	Fatigue	Fever	Night Sweats	Weight Gain/Loss	
Endocrine:	Changes in Growth	Hair Changes	Heat/Cold Intolerance	Excessive Thirst	
Eyes:	Blurred vision	Double Vision			
Neurological:	Clumsiness	Convulsion/Tremors	Headache	Memory Problems	Migraine
	Numbness/ Tingling	Seizures			
Skin:	Skin Growth/ Moles	Ulcers/ Blemishes	Slow Healing Wounds	Very dry Skin	
Hematology:	Anemia	Bleed Easily	Bruise Easily	Joint pain	Lymph Node Swelling
Psychiatric:	Depression	Hallucinations	Mood Changes	Sleep disturbance	Stress

QUAIL CREEK
EAR, NOSE, & THROAT CENTER

Robert H. Stroud, M.D.
Certified by the American Board of Otolaryngology
Sam J. Cunningham, M.D., Ph.D.
Certified by the American Board of Otolaryngology
Craig E. Fichandler,M.D.
Certified by the American Board of Otolaryngology
Wyatt J Weinheimer, M.D.
Certified by the American Board of Otolaryngology

Pediatric Questions (under 18)

Under 18 Smoke exposure? ____Yes ____No (if Yes please explain)

_____

Attend School/Daycare: ___Yes ____No

Name of School/Daycare: _____

How Many Children in class: _____

Who does the child live with? _____

Vaginal or Cesarean delivery? _____

Any Complications during pregnancy? ____Yes ____No (if yes please explain)

_____

Is there any family history of hearing loss? ___Yes ___No (if yes please explain)

_____

Did the child pass newborn hearing test? ____Yes ____No

Up to date on vaccinations: ____Yes ____ No