

Piedmont Ear, Nose & Throat Associates, P.C.

1720 Peachtree Street, Suite 200
Atlanta, GA 30309
(404)351- 5045 FAX (404)355-0691
TAX ID# 58-1203597

Today's Date: _____

- Kingsley N Chin, MD
- Karen K Hoffmann, MD
- Chester P Rollins, MD
- John R Coleman, MD
- John K Jarboe, MD

PATIENT'S INFORMATION

Patient's Name: _____ Male / Female
Last First MI

Mailing Address: _____ Social Security #: _____
 _____ Date of Birth: _____ Age: _____
 City/State/Zip: _____ Marital Status? Single / Married / Other
 Home Phone #: (_____) _____ Emergency Contact's Name: _____
 Work Phone #: (_____) _____ Emergency Contact's #: (_____) _____
 Mobile/Pager#: (_____) _____ Employed? Yes / No Student? Yes / No
 E-Mail Address: _____ Employer's Name: _____
 Pharmacy's #: (_____) _____ Address: _____

GUARANTOR'S INFORMATION

Name of Person Responsible for Payment: _____
 Relationship to Patient: Self / Spouse / Child / Other: _____
 Address: _____
 City/State/Zip: _____ Phone#: (_____) _____

REFERRAL INFORMATION

Referred by PCP (Primary Care Physician)? YES / NO Referring Name: _____
 Address: _____ PCP's Name: _____
 City/State/Zip: _____ Office #: (_____) _____

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Insurance's Name: _____ Address: _____ City/State/Zip: _____ Phone #: (_____) _____ Identification #: _____ Group #: _____ Effective Date: _____ Copay Amount: _____ Policy Holders' Name: _____ Social Security Number: _____ Birth Date: _____	Insurance's Name: _____ Address: _____ City/State/Zip: _____ Phone #: (_____) _____ Identification #: _____ Group #: _____ Effective Date: _____ Copay Amount: _____ Policy Holder's Name: _____ Social Security Number: _____ Birth Date: _____
--	--

I authorize Piedmont Ear, Nose, Throat & Related Allergy, PC to provide medical services and treatment deemed necessary. I am aware that all test procedures and surgeries may be applied to my deductible and/or coinsurance. I request medical benefits be paid directly to Piedmont, Ear, Nose, Throat & Related Allergy, PC. I authorize the release of medical information in order to process claims and collect payment on my behalf. I understand it is my responsibility to obtain referrals or authorizations required by my insurance plan. I accept responsibility for any services provided and understand any medical benefits to which I am entitled is a contract between myself and my carrier. I will be paying my copay/coinsurance/deductible at the time of service. A 24 hour notice is required for appointments that I am unable to keep. Failure to notify the practice will result in a \$50 No show Fee.

My signature below is my acknowledgement that Piedmont Ear, Nose, Throat & Related Allergy, PC has informed me of their Notice of Privacy Practices, as required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996.

Patient/Guarantor Signature: _____ Date: _____

**Piedmont Ear, Nose, Throat
& Related Allergy, P.C.**

Today's Date: _____

Patient Name: First: _____ Middle _____ Last _____

Who are you seeing today? Dr. Rollins Dr. Chin Dr. Jarboe Dr. Hoffmann
 Dr. Coleman Dr. Lindman

Who referred you here today? _____

If you were not referred by your doctor, select how you found out about our practice: Self referral
 Insurance Web Site Phone Book Friend/Family Member Our Web site Advertisement
Who is your primary care physician? _____ or select Don't have one

Why are you here today? Please write up to 1 paragraph describing your history. Please include current symptoms, how it was treated (write down prescription medications or over the counter medicines which you took for this condition). List any Xrays or Lab studies that were done.

How long have you had this problem? _____

What is your Occupation (patient)? _____

What is your marital status? single married partnered divorce

Are you a smoker? Yes No Former

If you selected Yes or Former, how much did you smoke ___ packs per (select one) day week social smoker rarely smoked.

How many years have you smoked? _____

If you quit smoking, what year did you quit? _____

Do you Drink Alcohol? Yes No Former

If you selected Yes or Former, how often do you drink? # drinks _____ daily weekly monthly or select rarely

If you quit drinking, what year did you quit? _____

Do you use any recreational drugs? Yes No Former

Family History:

Is there a family history of **allergies** or **asthma**? Yes No

Is there a family history of head and neck **cancer**? Yes No

Is there a family history of **hearing loss**? Yes No

Is there a family history of **thyroid cancer**? Yes No

**Piedmont Ear, Nose, Throat
& Related Allergy, P.C.**

Today's Date: _____

Surgical History:

Do you have a history of any ear, nose, or throat surgeries? Yes No

If yes, select the ones that you had and write the approximate year(s) it was done over the procedure.

Ears: Ear tubes Tympanoplasty Mastoidectomy Stapedectomy

Other Ear surgeries: _____

Nose: Rhinoplasty Septoplasty and/or inferior turbinate reduction Endoscopic Sinus Surgery Nasal Fracture Repair Other nasal surgery: _____

Mouth: Adenoidectomy Tonsillectomy Tonsillectomy and Adenoidectomy UPPP (Uvulopalatopharyngoplasty) Midfacial advancement for teeth overbite

Other mouth surgery: _____

Neck/Throat: Excision of lymph node Excision of salivary gland Excision of neck mass

Thyroidectomy Tracheotomy Vocal Cord Surgery Other neck/throat surgery _____

List other **MAJOR** surgeries that you have had and the year it was done: (example: heart surgery 1995)

List any **DRUG ALLERGIES** and the reaction:

	Medication Name	Adverse Reaction
None	_____	_____
<input type="checkbox"/>	_____	_____
	_____	_____

Do you have **LATEX** allergies? Yes No If yes, write the reaction: _____

Environmental and Food Allergies

Do you have any environmental allergies? Yes No

Do you have allergy symptoms all year long? Yes No

Have you ever had an allergy test before? Yes No

Have you ever been on allergy shots? Yes No

Do you have a history of hives or rash? Yes No

Do you have a history of food allergies? Yes No

Do you have chronic post nasal drip? Yes No

Do you get recurring sinus infections? Yes No

Do you wheeze or have trouble breathing? Yes No

Ear Problems

Do you have any problems hearing? Yes No

Do you have ringing in your ears? Yes No

Do you have any dizziness or vertigo? Yes No

Do have regular ear pain or itching? Yes No

When was your last hearing test? _____ Was it normal? Yes No

Voice Problems

Do you have any hoarseness? Yes No

Do you have any swallowing problems? Yes No

Do you have heart burn or acid reflux? Yes No

Do you cough or clear your throat frequently? Yes No

Do you have chronic sore throat? Yes No

Do You Have Sleep Apnea?

If you snore excessively and have any of the additional problems listed below, you may have sleep apnea. Please consider discussing a sleep evaluation with your doctor. Circle Yes or No to each question.

- | | | |
|---|-----|----|
| 1. Do you snore loudly? | Yes | No |
| 2. Does your bedroom partner complain about you snoring? | Yes | No |
| 3. Does your snoring wake you up at night? | Yes | No |
| 4. Do you or your bedroom partner notice that you make gasping and choking noises during sleep? | Yes | No |
| 5. Do you have dry mouth, sore throat or headaches in the morning? | Yes | No |
| 6. Do you often fall asleep during the daytime when you want to stay awake? | Yes | No |
| 7. Are you often tired during the day? | Yes | No |
| 8. Do you have high blood pressure? | Yes | No |

CIRCLE ALL Chronic Conditions that you have. Write down any other diseases not listed at bottom.

Patient Name: First: _____ **Middle** _____ **Last** _____

Template – Chronic Conditions

I have no chronic conditions

- | | | |
|--|--|---|
| Abdominal aortic aneurysm | Edema | Osteoarthritis |
| Alcoholism (former) | Endometriosis | Osteogenesis imperfecta |
| Allergic rhinitis (Seasonal Allergies) | Familial polyposis coli | Osteoporosis |
| Anemia | Fibrocystic Breast Disease | Pacemaker |
| Anemia, pernicious (B12 deficiency) | Fibromyalgia | Pancreatitis |
| Ankylosing Spondylitis | G6PD Deficiency | Panic attacks |
| Anorexia nervosa | GERD (Gastroesophageal Reflux Disease) | Parkinson's disease |
| Antibiotic prophylaxis needed | Glaucoma | Peptic Ulcer Disease |
| Anxiety disorder | Gout | Peripheral Vascular Disease |
| Aortic Regurgitation | Hashimoto's thyroiditis | Phenylketonuria |
| Aortic Stenosis | Headaches, migraine | Polio |
| Asthma | Headaches, tension | Polycystic Kidney Disease |
| Atrial Fibrillation | Hearing loss | Polycystic ovaries |
| Attention Deficit Disorder (ADD) | Heart disease | Polymyalgia Rheumatica |
| Benign prostate hypertrophy (BPH) | Heart Murmur requiring antibiotics for teeth | Prostatitis |
| Bipolar disorder | Hemophilia | Protein C Deficiency |
| Bleeding disorder | Hepatitis | Protein S Deficiency |
| Bronchitis, chronic | Hepatitis B | Pseudogout |
| Cancer, bladder | Hepatitis C | Psoriasis |
| Cancer, breast | Hereditary hemorrhagic telangiectasia | PSVT |
| Cancer, cervical | Hirsutism | Pulmonary Hypertension |
| Cancer, colon | HIV+ (Human Immunodeficiency Virus) | Radiation therapy |
| Cancer, endometrial | Hyperlipidemia (High Cholesterol) | Renal failure |
| Cancer, lung | Hyperparathyroidism | Restless leg syndrome |
| Cancer, other List: _____ | Hypertension | Rheumatic Fever |
| Cancer, ovarian | Hyperthyroidism | Rheumatoid Arthritis |
| Cancer, pancreatic | Hypertrophic Obstructive Cardiomyopathy | Rosacea |
| Cancer, prostate | Hypogammaglobulinemia | Sarcoidosis |
| Cancer, renal | Hypothyroidism | Scarlet Fever |
| Cancer, skin | Infertility | Schizophrenia |
| Cancer, stomach | Interstitial Cystitis | Scoliosis |
| Cancer, thyroid | Irritable Bowel Syndrome | Seizures |
| Cardiomyopathy | Kidney disease | Sick Sinus syndrome |
| Carpal Tunnel | Lactose intolerance | Sickle cell trait |
| Cerebral aneurysm | Leukemia | Sleep apnea |
| Cerebrovascular accident (CVA) | Lupus erythematosus (SLE) | Thalassemia |
| Cholelithiasis | Lymphoma; Hodgkins | Thyroid disease |
| Chronic Lymphocytic Leukemia (CLL) | Lymphoma; Non-Hodgkins | TIA's (Transient Ischemic Attacks) |
| Cirrhosis | Melanoma of the skin | TMJ (Temporal Mandibular Joint Disease) |
| Colon polyps | Menstrual problems | Tobaccoism |
| Congenital heart disease | Mental Retardation | Tremor, essential |
| Congestive heart failure | Migraine Headaches | Tuberculosis |
| COPD | Mitral Stenosis | Ulcerative colitis |
| Coronary artery disease | Mitral Valve Prolapse | Urinary stress incontinence |
| Crohn's Disease | Multiple Sclerosis | Uterine fibroids |
| Cystic fibrosis | Muscular dystrophy | Venous insufficiency |
| Deafness | Myasthenia Gravis | Von Willebrand's Disease |
| Dementia | Myocardial infarction | Wegener's Granulomatosis |
| Dementia, Alzheimer's | Nephrolithiasis | **LIST ANY OTHER CHRONIC |
| Depression | Nephrotic Syndrome | CONDITIONS HERE** |
| Developmental delay | Neurofibromatosis | _____ |
| Diabetes Mellitus Type I | Neuropathy | _____ |
| Diabetes Mellitus Type II | Obesity | _____ |
| Diverticulosis | Obesity, morbid | _____ |
| Eczema | Obstructive Sleep Apnea | _____ |

CIRCLE the medications that you take. Those that are **NOT** listed, **write in at the bottom** of the list.

ACCUPRIL	CLARINEX	HYDROXYZINE HCL
ACETAMINOPHEN (TYLENOL)	CLARITIN	HYZAAR
ACIPHEX	CLARITIN D	IBUPROFEN
ACTONEL	CLONAZEPAM	IMITREX
ACTOS	CLONIDINE HCL	INDERAL LA
ADDERALL XR	CLOTRIMAZOLE BETAMETHASONE	ISOSORBIDE MONONITRATE
ADVAIR DISKUS	COMBIVENT	KARIVA
ADVIL	CONCERTA	KLONIPIN
ALBUTEROL	COREG	KLORCON
ALDACTONE	COSOPT	LAMICTAL
ALEVE	COTRIM	LAMISIL
ALLEGRA	COUMADIN	LANOXIN
ALLEGRA D	COZAAR	LANTUS
ALLERGY INJECTIONS	CRESTOR	LASIX
ALLOPURINOL	CYCLOBENZAPRINE HCL	LESCOL
ALPHAGAN P	DEPAKOTE	LESCOL XL
ALPRAZOLAM	DEPAKOTE ER	LEVAQUIN
ALTACE	DETROL LA	LEVOTHROID
AMARYL	DIAZEPAM	LEVOXYL
AMBIEN	DIDANOSINE	LEXAPRO
AMITRIPTYLINE HCL	DIFLUCAN	LIPITOR
AMOXICILLIN	DIGITEK	LISINOPRIL
AMOXICILLIN/CLAVULANATE	DILANTIN	LISINOPRIL/HCTZ
APRI	DILTIAZEM HCL	LORAZEPAM
ARICEPT	DIOVAN	LOTENSIN
ARMOUR THYROID	DIOVAN HCT	LOTREL
ASPIRIN	DITROPAN XL	LOW-A1870GESTREL
ASTELIN	DOXYCYCLINE HYCLATE	MACROBID
ATACAND	DURAGESIC	MECLIZINE HCL
ATENOLOL	DYAZIDE	MEDROXYPROGESTERONE
ATROVENT	EFFEXOR XR	METFORMIN HCL
AUGMENTIN ES600	ELIDEL	METHOTREXATE
AUGMENTIN XR	ENALAPRIL MALEATE	METHYLPREDNISOLONE
AVALIDE	ENDOCET	METOCLOPRAMIDE HCL
AVANDIA	ESTRADIOL	METOPROLOL TARTRATE
AVAPRO	EVISTA	MIACALCIN
AVELOX	FIORINAL	MICROGESTIN FE
AVIANE	FLOMAX	MIRALAX
BACTROBAN	FLONASE	MOBIC
BENICAR	FLOVENT	MONOPRIL
BENNADRYL	FLUOXETINE HCL	MOTRIN
BENZACLIN	FOLIC ACID	NAPROXEN
BIAXIN	FOLTX	NASACORT AQ
BIAXIN XL	FOSAMAX	NASONEX
BISOPROLOLFUMARATE	FUROSEMIDE	NECON
CARISOPRODOL	GEMFIBROZIL	NEURONTIN
CARTIA XT	GLUCOPHAGE XR	NEXIUM
CEFUROXIME	GLUCOTROL XL	NIASPAN
CEFZIL	GLUCOVANCE	NIFEDIAC CC
CELEBREX	GLYBURIDE	NIFEDIPINE ER
CELEXA	GUAIFENESIN	NITROQUICK
CEPHALEXIN	HUMALOG	NORVASC
CHLORTRIMETON	HUMULIN 70/30	OMEPRAZOLE
CILOXAN	HUMULIN N	OMNICEF
CIPRO	HYDROCHLOROTHIAZIDE	ORAPRED
CIPROFLOXACIN HCL	HYDROCODONE W APAP (LORTAB)	ORTHO EVRA

CIRCLE the medications that you take. Those that are **NOT** listed, **write in at the bottom** of the list.

ORTHO NOVUM
ORTHO TRI-CYCLEN
ORTHO TRI-CYCLEN LO
OXYCODONE W APAP
OXYCONTIN
PAROXETINE HCL
PATANOL
PAXIL
PAXIL CR
PENICILLIN VK
PERCOCET
PHENYTOIN SODIUM
PLAQUENIL
PLAVIX
PLENDIL
POTASSIUM CHLORIDE
PRAVACHOL
PRAZOSIN
PREDNISONE
PREMARIN
PREMPRO
PREVACID
PRILOSEC
PROMETHAZINE HCL
PROMETHAZINE WITH CODEINE
PROMETRIUM
PROPOXYPHENE NAPSYLATE
PROPRANOLOL HCL
PROSCAR
PROTONIX
PROZAC
PULMICORT
RANITIDINE HCL
REMERON
RHINOCORT AQUA
RISPERDAL
ROXICET
SEROQUEL
SINGULAIR
SKELAXIN
SMZ/TMP
SPIRONOLACTONE
STRATTERA
SUDAFED
SYNTHROID
TEMAZEPAM
TEQUIN
TERAZOSIN HCL
TETRACYCLINE
TIAZAC
TIMOLOL MALEATE
TOBRADEX
TOPAMAX
TOPROL XL
TRAMADOL HCL
TRAZODONE HCL

TRIAMCINOLONE ACETONIDE
TRIAMTERENE/HCTZ
TRICOR
TRILEPTAL
TRIMOX
TRIVORA 28
TUSSIONEX
TYLENOL
ULTRACET
VALTRES
VERAPAMIL HCL
VIAGRA
VIOXX
WARFARIN SODIUM
WELLBUTRIN SR
XALATAN
XOPENEX
XYZAL
YASMIN 28
VERAMYST
ZESTORETIC
ZETIA
ZITHROMAX
ZOCOR
ZOLOFT
ZOVIRAX
ZYPREXA
ZYRTEC
ZYRTEC D

**VITAMINS, MINERALS, &
HERBS**

ACIDOPHILUS
CALCIUM
CHROMIUM
COENZYME Q10
COPPER
ECHINACEA
FISH OIL
GARLIC
GINGKO
GINGSENG
GLUCOSAMINE CHONDROITIN
IRON
JUICE PLUS
L GLUTATHIONE
L LYSINE
LECITHIN
MAGNESIUM
MOLYBDENUM
MULTIVITAMINS
NIACIN
PANTOTHETIC ACID
SAWPALMETTO
SELENIUM
ST. JOHNS WART

VITAMIN A
VITAMIN B COMPLEX
VITAMIN B12
VITAMIN B6
VITAMIN C
VITAMIN D
VITAMIN E
ZINC

HIV MEDICATIONS

3TC/EPIVIR
COMBIVIR
CRIXIVAN
DDI/DIDANOSINE
EMTRIVA
EPIVIR
EPZICOM
FORTOVASE
FUZEON
INVIRASE
KALETRA
LEXIVA
NORVIR
RESCRIPTOR
RETROVIR
REYATAZ
SUSTIVA
TRUVADA
VIDEX
VIRACEPT
VIRAMUNE
VIREAD
ZERIT
ZIAGEN

OTHER MEDICATIONS LIST HERE

I don't take any medications

*Have you taken any aspirin products (Bayer/Alka-Seltzer) within 2 weeks?

YES NO

*Have you taken any non-steroidal pain medications (Advil, Nuprin, Motrin, ibuprofen) within 2 weeks? YES NO