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PATIENT INFORMATION

Name (First, M.I., Last) _____
Date of Birth: _____ Age: _____ Social Security # _____ Sex (M/F) _____
Address: _____ (City, State, Zip) _____
Phone # _____ Cell # _____ Work # _____
Married/Single/Other _____ email address: _____
Responsible Party _____ Relationship: _____
Employer & Occupation _____
Reason for Today's Visit? _____
How were you referred to us? Hospital/Physician/ Friend or Patient/ Other _____
In case of an emergency, who should we notify? _____ Relationship _____
Address: _____ Phone # _____
Primary Care Physician: _____
I give permission for Milton Hall Surgical Associates/ENT Institute to discuss my information with the following person: _____ Relationship _____

PRIMARY INSURANCE

Insurance Company: _____ HMO PPO POS Indemnity
Insured's Name: _____ Insured's Employer _____
Insured's Date of Birth: _____ Insured's Social Security # _____
Claim's Mailing Address: _____
Insurance Telephone # _____ Policy # _____

SECONDARY INSURANCE

Insurance Company: _____ HMO PPO POS Indemnity
Insured's Name: _____ Insured's Employer _____
Insured's Date of Birth: _____ Insured's Social Security # _____
Claim's Mailing Address: _____
Insurance Telephone # _____ Policy # _____

Co-pays, deductibles and any other patient responsibility fees are due when services are rendered. If you have any questions about fees, please check with us prior to being seen. I understand that insurance will be filed by your office as a courtesy and does not constitute a contract between the physician and insurance company for payment of your services.

Patient Signature/ Authorized Guardian

Date

Print Patient Name

Patient Name: _____ Date of Birth _____

YES NO Do you take any prescription, over-the-counter medication, or herbal therapies (including Aspirin, Advil, vitamins, etc)? _____

YES NO Are you allergic to Latex or any medications? If yes, please list and explain type of reaction.

YES NO Do you smoke? If yes, number of packs per day? _____ how long? _____

YES NO Do you drink any alcoholic beverages? Number of drinks per day? _____

YES NO Have you ever had a positive blood test for HIV?

List all operations you have had:

Operation	Year	Doctor	City, State

Current Weight _____ Current Height _____

To the best of your knowledge, have YOU or ANY members of your family ever had problems with any of the following:
 (Please explain all "YES" answers). Please note this is not a complete list.

MYSELF

FAMILY MEMBER

YES	NO			
		Eyes/Ears/Nose		
		Mouth/Throat		
		Heart Problems (hypertension, heart attack, heart murmur)		
		Respiratory (Asthma/ Emphysema/Tuberculosis)		
		Stomach Problems (Reflux, ulcers, hiatal hernia,bleeding)		
		Genital/Urine/Liver Problems(hepatitis,cirrhosis)		
		Musculoskelatal/Orthopedic Problems(arthritis/broken bones)		
		Skin/Breast		
		Neurological (seizure,stroke,spinal cord injury, migraines, weakness)		
		Psychiatric (depression/anxiety)		
		Thyroid problems/Diabetes/ Endocrine Problems		
		Bleeding Problems (sickle cell, anemia)		
		Allergy/Immune Problems (HIV, Immune suppression)		