



CARLSON
EAR NOSE & THROAT ASSOCIATES
HEALTH QUESTIONNAIRE

NAME _____ SEX _____ AGE _____ HEIGHT _____ WEIGHT _____
 PLACE OF BIRTH _____ REASON FOR VISIT _____

LIST OF MEDICATIONS: (IF ADDITIONAL SPACE IS NEEDED, PLEASE CONTINUE ON THE BACK OF THIS PAGE)

DRUG	DOSE	FREQUENCY	YEAR STARTED

OTC MEDICATIONS (E.G. VITAMINS) _____

History of Drug Abuse? _____ HIV Test? _____ Positive or Negative? _____

MRSA Test? _____ Year? _____ Positive or Negative? _____

ALLERGIES (FOOD AND MEDICATIONS) _____

Preferred Pharmacy/ Cross Streets _____

CAT SCAN OR MRI YEAR _____ LOCATION _____ RESULTS _____

OF HEAD OR NECK YEAR _____ LOCATION _____ RESULTS _____

FAMILY HISTORY

	FATHER	MOTHER	SISTERS	BROTHERS	OTHERS
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL PAST MEDICAL HISTORY

(IF ADDITIONAL SPACE IS NEEDED, PLEASE CONTINUE ON THE BACK OF THIS PAGE)

SURGERIES	TYPE	LOCATION	YEAR

CIRCLE ALL THAT APPLY TO YOU:

- | | | | | |
|---------------------|------------------------|-----------------|------------------|----------------|
| Hearing Loss | Swollen Neck | Heart Murmur | Herpes | Easy Bleeding |
| Dizziness | Glands | Palpitations | Venereal Disease | Bruise Easily |
| Ringing in the Ears | Heartburn | Varicose Veins | Chlamydia | Anemia |
| Ear Drainage | | Irregular Pulse | Gonorrhea | |
| Ear Pain | Diff. Swallowing | | | Depression |
| TMJ Syndrome | Hoarseness | Jaundice | Arthritis | Mental Illness |
| | Thyroid Disease | Kidney Stones | Gout | Seizures |
| Nose Bleeds | | Colitis | Recent Weight | Migraine |
| Nasal Drainage | Cataracts | Hepatitis | Loss | Headaches |
| Nasal Polyps | Vision Problems | Diabetes | Cancer | |
| Headaches | | | | |
| Sore Throat | Hypertension | Prostate Prob. | | |
| | Coronary Heart Disease | | | |



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PATIENT INFORMATION

NAME: LAST _____ FIRST _____ M.I. _____
 DATE OF BIRTH _____ S.S.# _____ MAIDEN NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 HOME PHONE _____ CELL PHONE _____
 EMPLOYER _____ WORK PHONE _____
 PRIMARY CARE PHYSICIAN _____
 REFERRED BY _____
 OCCUPATION: _____ E-MAIL ADDRESS _____

SECONDARY ADDRESS

PRIMARY INSURANCE HOLDER

NAME _____ DATE OF BIRTH _____
 RELATIONSHIP TO PATIENT _____ S.S.# _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____ Phone _____
 EMPLOYER _____ ADDRESS _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____
 SUBSCRIBER ID NUMBER _____
 GROUP NUMBER _____ SUBSCRIBER'S NAME _____

SECONDARY INSURANCE HOLDER

NAME _____ DATE OF BIRTH _____
 RELATIONSHIP TO PATIENT _____ S.S.# _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 EMPLOYER _____ ADDRESS _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____
 SUBSCRIBER ID NUMBER _____
 GROUP NUMBER _____ SUBSCRIBER'S NAME _____



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EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE _____ WORK PHONE _____

CONSENT FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE JAMES R. CARLSON, MD, THOMAS S. KANG, MD AND/OR
JONATHAN LARA, DO TO TREAT (PATIENT'S NAME) _____
RELATIONSHIP TO PATIENT _____ SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have received a copy of Carlson Ear Nose and Throat Associates' Notice of Privacy Practices. This notice describes how Dr. James Carlson, Dr. Thomas Kang, and/or Dr. Jonathan Lara, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding health information.

Signature of Patient (or Personal Representative) Date

Relationship to patient



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By signing below, I give my consent for Carlson Ear Nose and Throat Associates to disclose my record for treatment, payment and healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that this office has already taken action in reliance thereon. Additionally, this form allows me to identify restrictions on the disclosure of my records. These restrictions will affect the way health information can be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that if Dr. Carlson, Dr. Kang and/or Dr. Lara do not agree with the specified restrictions and feels that appropriate care cannot be given with the specified restrictions, they have the right to refuse treatment.

As part of my healthcare, I understand that oral communication is important and that if I do not specify individuals to whom my information may be released to, Carlson Ear Nose and Throat Associates will not disclose this information under any circumstance without a written authorization.

In my absence, Carlson Ear Nose and Throat Associates may discuss my medical condition with the following individuals:

Name/Relationship to Patient

Name/Relationship to Patient

Name/Relationship to Patient

Name/Relationship to Patient

- I agree that Carlson Ear Nose and Throat Associates may leave detailed messages regarding my medical condition at the following phone number(s)

- I do not wish to have messages left with individuals or answering machines.
- Additional restrictions for the use or disclosure of my health information:

- No restrictions are in place at the time of signing this consent.

Patient's Printed Name

Patient's Signature

Date



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OUR CREDIT POLICY

Carlson Ear Nose and Throat Associates will charge a late payment on any part of the "Balance Forward" as shown on the monthly statements which remain unpaid 30 days or more after the first billing date. The ANNUAL PERCENTAGE RATE is approximately 10% per annum. You will be responsible for any collection fees incurred by Carlson Ear Nose & Throat Associates.

All payments shall be first applied to any late payment charge assessed on the account and then to the oldest charges unpaid, then to any current charges.

You are responsible for payment of your account balance regardless of your insurance coverage. We cannot accept responsibility for negotiating settlement with your insurance on a disputed claim. Notwithstanding insurance benefits that may have accrued, the late payment charges set out above shall be assessed against all accounts, even if the account will ultimately be paid wholly or partly by insurance benefits. **WE DO NOT CURRENTLY ACCEPT WORKERS COMPENSATION, THIRD PARTY BILLING, OR STATE FUNDED MEDICAL PLANS SUCH AS AHCCCS, MERCY CARE, ETC.**

FINANCIAL AGREEMENT AND VERIFICATION

The undersigned areas, whether he/she signs this form as a patient or an agent of the patient, that in consideration of the services to be rendered by Carlson Ear Nose and Throat Associates, he/she obligates himself/herself to pay the account in full within 30 days of the billing date, and with the regular rates and terms, which are subject to change without notice. In the event this account is referred for collection, the patient or patient's agent shall pay reasonable attorney's fees and collection expenses. We have the option to report your account status to any credit reporting agency such as a credit bureau. I have read and understand the information on this form and approve the annual percentage rate, the method of computing the late charges, and all other terms. I certify the information given is correct to the best of my knowledge.

Patient/Agent Signature: _____ Date: _____

INSURANCE RELEASE

I authorize Carlson Ear Nose and Throat Associates to release any medical information or other information to my insurance company in the course of my examination or treatment. I also request payment of government benefits to either myself or the party accepting assignment.

Patient/Agent Signature: _____ Date: _____

INSURANCE AGREEMENT

I authorize Carlson Ear Nose and Throat Associates to file insurance claims on my behalf for the services rendered and accept payments from my insurance carrier(s). I realize I am responsible for the full charges incurred on my account regardless of insurance coverage.

Patient/Agent Signature: _____ Date: _____



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The Epworth Sleepiness Scale

Please rate the following on a scale from 0-3

- 0 – no chance of dozing
- 1 – slight chance of dozing
- 2 – moderate chance of dozing
- 3 – high chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e. theater, meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	

Total Epworth Score: _____

NAME: (please print) _____



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HISTORY AND PHYSICAL FOR DIZZINESS

Name: _____ Date: _____ Age: _____

Brief History of dizziness: _____

Onset: _____ Frequency: _____

Duration of spells: seconds minutes hours days constant

Symptoms (circle): nausea vomiting room spinning
staggering (right/left) cold sweats passing out
light headed falling constant/intermittent

Positional Correlation (circle): lying flat turning in bed (right/left)
fast movement looking up/down

Hearing loss? _____ Which ear? _____ Steady or fluctuant? _____
Tinnitus? _____ Which ear? _____ Steady or fluctuant? _____
Fullness in ears? _____ Which ear? _____ Steady or fluctuant? _____

Previous testing or X-rays? _____

Previous diagnosis? _____

Previous treatment for dizziness? _____ by Doctor _____

General history (please circle those that apply):

heart slurred speech ear injury
hypertension blurred vision head injury
hypotension stroke anxiety
circulation confusion nicotine
anemia loss of consciousness alcohol
diabetes high cholesterol caffeine

Physician Use Only:

Neuro-Otological Examination:

Romberg: Sharpened Tandem Tandem Sharpened
Cerebellar: Finger to nose Rapid alternating motion
Cranial N VII-XII: EOM: Gaze nystagmus
Eyebrow raise
Eye squeeze
Smile symmetry
Cheek puff
Shoulder shrug
Tongue symmetry
Gag reflex

POSITIONAL TEST: Right Left
Nystagmus: Horizontal Rotary Fatigable Latent

AUDIOGRAM Results: Normal Sensorineural loss Conductive loss Right Left

VNG Results: BPPV Central Peripheral Right Left Cervical Vestibular Ocular Reflex

MRI/CT Results :