

RICHARD A. FLAIZ, M.D., F.A.C.S.
E.N.T., FACIAL PLASTIC & LASER CENTER
600 N.W. 11th, SUITE # E-21
HERMISTON, OR 97838-8603
(541) 567-2270

Today's Date _____

NEW PATIENT INFORMATION

PAYMENT IS EXPECTED AT THE TIME THAT SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER.

YOU MUST HAVE AN ADULT WITH YOU IF YOU ARE UNDER THE AGE OF 16 OR YOU WILL NOT BE SEEN BY THE DOCTOR.

PLEASE PRINT ALL INFORMATION

Patient's Name _____ Age _____ SSN # _____
Last FIRST & INITIAL

Patient's Mailing Address _____
City State Zip

Patient's E-Mail Address _____

Employer _____ Home Phone _____ Work Phone _____

Date of Birth _____ Sex M F Married / Single / Widowed Religion _____

Referring Physician _____ If none, how did you hear about our practice? _____

Local person we can contact in case of emergency: Name _____ Phone # _____

Nearest relative not living with you.

Name _____ Address _____ Phone # _____

Person Financially Responsible _____ D.O.B. _____
Last FIRST & INITIAL PHONE NO.

Address _____
City State Zip

Employer _____
Phone No.

Employer Address _____
City State Zip

Social Sec. # _____ Relationship of Patient to Responsible Party: Self Spouse Child Other _____

Spouse _____ D.O.B. _____
Last FIRST & INITIAL PHONE NO.

Address _____
City State Zip

Employer _____
Phone No.

Employer Address _____
City State Zip

Insurance Information

Name of Policyholder _____ Date of Birth _____

Address (if different than above) _____

Primary: Company & Address _____

Policy # _____ Group # _____ Medicare number & letter _____ Welfare number _____

Secondary: Company & Address _____

Name of Policyholder _____ Date of Birth _____

Policy # _____ Group # _____ Medicare number & letter _____ Welfare number _____

Auto Accident? Yes No Place (State) _____ Other Accident? Yes No

COMPLETE ONLY IF INDUSTRIAL INJURY (ON THE JOB)

Where employed at time of injury _____ Date of injury _____

Name of Industrial Insurance _____ Claim # _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize Richard A. Flaiz, M.D. to release information requested by my insurance company or Workers' Compensation carrier. I also authorize Richard A. Flaiz, M.D. to release information to any hospital or physician to which I may be referred by this office. Photography for teaching purposes may also be performed.

Signature _____ Date _____ Relationship to Patient _____

ASSIGNMENT OF BENEFITS:

I hereby authorize assignment and payment directly to Richard A. Flaiz, M.D. major medical benefits due

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

Signature _____ Date _____ Relationship to Patient _____

YOU MAY BE CHARGED FOR MISSED APPOINTMENTS.

Medical History Questionnaire

Name: _____

1. What is your present problem?

1. _____
2. _____

2. How long, and what have you done about it? _____

3. Have you had any surgeries in the past? If so, please list them:

1. _____ 3. _____
2. _____ 4. _____

4. Have you had any of the following?

Diabetes Mellitus High Blood Pressure Emphysema Heart Disease

5. What medications are you allergic to, if any? _____ None

What happens? _____

6. Are you taking any medications at this time? If so, please list them:

1. _____ 3. _____
2. _____ 4. _____

7. Do you smoke? _____ How much? _____ How long? _____

8. Do you drink alcoholic beverages? _____

9. Please check the following areas you are currently having problems with:

- | | | |
|------------------------------|------------------------|------------------------------|
| Frequent or severe headaches | Bad breath | Yellow jaundice |
| Head injury | Bad tastes | Hernia |
| Facial pain | Previous sinus surgery | High blood sugar |
| Eye trouble | Frequent sore throats | Kidney bladder trouble |
| Frequent Earaches | Frequent tonsillitis | Back trouble |
| Perforated ear drum | Heavy snoring | Arthritis |
| Ear Drainage | Difficulty swallowing | Broken bones |
| Hearing Loss | Thyroid trouble | Varicose veins |
| ringing in ears | Asthma or wheezing | Anemia |
| Ear pressure or blockage | Shortness of breath | Excessive bleeding on injury |
| Light headedness/dizziness | Bronchitis | Unusual weight gain or loss |
| Nose allergy | Chronic cough | Frequent fatigue |
| Hay fever | Lung trouble | Skin problems |
| History of broken nose | Tuberculosis | Difficulty sleeping |
| Constant nasal obstruction | Chest pain | Depression |
| Frequent nasal discharge | Heart trouble | HIVG |
| Sinus trouble | Heartburn/indigestion | |

Please explain: _____

Please indicate who, if anyone, in your family had any of the following:

Diabetes: _____

High Blood Pressure: _____

Cancer: _____

Heart Disease: _____

Seizure Disorders: _____