Ear, Nose, Throat, & Allergy of Northwest Georgia
Raymond Howard, M.D.

107 John Maddox Drive   Rome, GA 30165

Patient: Preferred Name: ____________________ Date: ____________

First Name: ______________ Middle: ______________ Last: ______________

Date of Birth: ______________ Age: ________ Sex: Male / Female SSN: ______________

Race: ____________ Ethnicity: ______________ Preferred Language: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Mailing Address: ____

City: ______________ State: ______________ Zip: ______________

Phone: Home: ______________ Work: ______________ Cell: ______________

Email: ____

Preferred Method of Communication: Call: ☐Home ☐ Work ☐ Cell, ☐Text, ☐ Email, ☐ Patient Portal

Employer: ____

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Pharmacy Name: ______________ **Location:** ______________ **Phone:** ______________

Spouse Full Name: ______________________ Date of Birth: ______________

SSN: ______________________ Cell Phone: ______________

Email: ____

Employer: ______________________ Work Phone: ______________

IF PATIENT IS UNDER 18 OR STILL ON PARENT'S INSURANCE THIS IS REQUIRED

Mother / Guardian Name: ______________________ Date of Birth: ______________

Address if Different: ____

City: ______________ State: __________ Zip: __________ SSN: ______________

Phone: Home: ______________ Work: ______________ Cell: ______________

Email: ______________________ Employer: ______________

Father / Guardian Name: ______________________ Date of Birth: ______________

Address if Different: ____

City: ______________ State: __________ Zip: __________ SSN: ______________

Phone: Home: ______________ Work: ______________ Cell: ______________

Email: ______________________ Employer: ______________

Who does patient live with: ______________________ Relationship if not parent: ______________

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION – SIGNATURE REQUIRED

HIPPA Notification: ENT of NWGA complies with HIPPA laws & privacy acts. Our privacy policy is posted in the lobby. According to these policies, I understand that unless written permission is given:

Patient information can only be released to the following individuals:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

_______ I authorize ENT of NWGA to leave messages on my answering machine regarding my care and/or appointments.
I authorize payment directly to ENT of NWGA and authorize the release of medical information to my insurance carrier to process claims. I also authorize ENT of NWGA to access my pharmacy benefits for a list of my medications and to prescribe my prescriptions electronically. I understand that ENT of NWGA will only send prescriptions electronically and a hand-written prescription will not be given.

_______ I authorize Dr. Raymond Howard and Mid-level providers at ENT of NWGA to examine and treat me. This may include procedures that are necessary to diagnose my problem. Included in these procedures are the possibilities of the following:

1) Flexible Laryngoscopy —the use of a flexible scope to check the throat.
2) Nasal Endoscopy — the use of an endoscope to check the nose and sinus. This may include cleaning for sinus surgery or nasal cautery and nosebleeds.
3) Biopsy if deemed necessary for the diagnosis of my problem.
4) Ear or nasal cleanings/debridement.

_______ I understand that there are risks involved in any procedure including, but not limited to: bleeding, scarring, pain, and/or infection. I understand that my insurance company may code these procedures as a surgical procedure and will pay accordingly.

_______ I understand that it is my responsibility to provide my correct/current insurance card and information and to obtain a *referral* for my insurance if one is needed for my policy. If do not have my referral, correct/current insurance card, information, or if my claim is denied, I will be responsible for payment of my bill, which includes but is not limited to any amount that the insurance deems to be patient's responsibility.

I/We have read this disclosure and agree that ENT of NWGA, its employees and/or agents may contact me/us as described above.

X ______________________________ X ______________________________

Print: Patient/ Parent, Guardian/ Legal Representative Sign: Patient/ Parent, Guardian/ Legal Representative

______________________________ ______________________________

Patient's name if not person signing Date

Ear, Nose, & Throat of NWGA

Raymond Howard, M.D.

Patient Medical History

Name: ____________________ Age: ________ Date: ____________

Who referred you to our practice? ____________________

Reason for visit? ____________________

What date did symptoms begin? ____________________

Problems (Please Check Appropriate Boxes)

☐ Hearing Loss	☐ Vision Problems	☐ Sore Throat	☐ Neck Pain
☐ Ear Fullness	☐ Nose Congestion	☐ Snoring	☐ Neck Mass
☐ Ear Ringing	☐ Nose Discharge	☐ Heartburn	☐ Dizziness
☐ Ear Pain	☐ Post Nasal Drip	☐ Hoarseness	☐ Vertigo
☐ Swallowing Problems	☐ Nose Bleeds	☐ Allergies	☐ Headaches

☐ Other ____________________

Past Medical HISTORY: (Please Check All Appropriate Boxes)

☐ Heart Attack	☐ Thyroid Disorder	☐ Glaucoma	☐ Seizures
☐ Asthma	☐ Coronary Disorder	☐ Hypertension	☐ HIV
☐ Diabetes	☐ Bleeding Disorder	☐ Heart Failure	☐ Hepatitis
☐ Emphysema	☐ Kidney Disorder	☐ Arthritis	
☐ Hepatitis	☐ Stroke	☐ Cancer	

☐ Other ____________________

Past Surgical history: (Please Check All Appropriate Boxes)

☐ Ear Tubes	☐ Tonsils	☐ Back/Neck	☐ Appendix
☐ Nasal	☐ Adenoids	☐ Heart Bypass	☐ Gall Bladder
☐ Sinus	☐ Facial	☐ Hernia	☐ Cataracts

☐ Other ____________________

Family Medical History: (Please Check All Appropriate Boxes)

☐ Strokes	☐ Thyroid Disorders	☐ Hypertension	☐ Heart Disease
☐ Diabetes	☐ Allergies	☐ Hearing Loss	☐ Asthma
☐ Cancer	☐ Other ____________		

Social History (Please Check All Appropriate Boxes)

Alcohol:	Current/Daily ☐	Some days/Occasionally ☐	Never ☐	Former ☐
Second Hand Smoke:	Current/Daily ☐	Some days/Occasionally ☐	Never ☐	Former ☐
Tobacco/Cigarettes:	Current/Daily ☐	Some days/Occasionally ☐	Never ☐	Former ☐
Tobacco/ E-Cigs/Vape:	Current/Daily ☐	Some days/Occasionally ☐	Never ☐	Former ☐

List ANY Drug Allergies:

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List All Medications you are CURRENTLY taking: (any additional room needed please use the back of this form)

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Patient Signature ____________________