(circle one)TERRY H. MCMILLAN,M.D., MATTHEW D. GILLIHAN, M.D.
1130 Commerce Drive, Las Cruces, NM 88011 575.521.3025/FAX 575.521.3565

PLEASE MARK N/A IF NON-APPLICABLE)

PATIENT INFORMATION (Please Print)

Name: ______________________ **DOB:** ________ **/AGE:** ________ **/SS#** ________________
Last First M.I.

Gender: Male ________ **Female** ________________

Address: ____
Physical / PO Box City State Zip

Home Ph# ________________ **Wk#** ________________ **Cell#** ________________

EMAIL Address: ____

Employer: ________________ **Ph#** ________________ **Occupation:** ________________
Name

____
Employer Address City State Zip

SPOUSE/PARENT/GUARDIAN INFORMATION:

Full Name: ________________________________ **(Check One) Spouse** ______ **Parent/Guardian** _____

Name & Address of Employer: ____
(of responsible party/must be completed)

Home Ph# ________________ **Wk#** ________________ **Cell#** ________________

EMERGENCY CONTACT:

Full Name: ________________________________ **Contact Ph#** ________________________

Relationship to Patient: ________________________ **2nd Contact Ph#** ________________________

INSURANCE INFORMATION:

Primary Insurance Name: ________________________ **Grp** ____________ **ID#** ________________

Effective Date: ________ **Policy Holder Name:** ____

DOB ________ **SS#** ________________________ **Relationship to Patient:** ________________

Secondary Insurance Name: ________________________ **Grp** ____________ **ID#** ________________

Effective Date: ________ **Policy Holder Name:** ____

DOB ________ **SS#** ________________________ **Relationship to Patient:** ________________

DR REQUESTING CONSULT:

____
Full Name Title: MD, P.A., NP /Other

PH# ________________ FAX# ________________ Address: ________________________

Name: Date: Front & Back

Chief Complaints: (what are we seeing you for today)

____

____

____

____

Review of Systems/Past Medical History
(Circle all that apply)

Constitutional

Chills. Fever. Weight Gain. Weight Loss.

Head

Fainting. Head Injury. Headaches.

Eyes

Blurry Vision. Cataracts. Double Vision. Excessive Tearing. Eye Pain.
Glaucoma. Infections.

ENT

Nose

Discharge. Frequent Colds. Hay Fever. Infections. Nasal Obstruction.
Nosebleeds. Sinus Infections.

Mouth

Bleeding Gums. Change in Dentition. Hoarseness. Postnasal Drip.
Tongue Burning. Voice Changes.

Ears

Discharge. Dizziness. Hearing Aid. Hearing Impairment. Infections.
Pain. Ringing in Ears.

Throat Neck

Frequent Sore Throats. Lumps. Tenderness. Enlarged Tonsils.
Pain with Swallowing

NAME: ______________________

NAME OF PHARMACY______________________

ADDRESS______________________

PHONE: ______________________

DRUG ALLERGIES:

NONE(x)__________ OR LIST BELOW

Name Reaction

1.______________________

2.______________________

3.______________________

MEDICATIONS and DOSAGE:

1.______________________

2.______________________

3.______________________

4.______________________

5.______________________

6.______________________

7.______________________

FAMILY HISTORY (Circle all that apply)

Heart Disease / High Blood Pressure / Diabetes / Stroke

Bleeding Disorder / Deafness/ Thyroid Disorder

Thyroid Cancer / Anesthetic reaction (NOT nausea)

SOCIAL HISTORY:

Type	Amount/Day	Years

TOBACCO ______________________

ALCOHOL: ______________________

STREET DRUGS ______________________

D.O.B. ______________________

SURGERIES: (PLEASE CIRCLE ALL THAT APPLY)

Type	Year

ADENOIDECTOMY
EARS TUBES/BMT
EAR SURGERY
NECK MASS REMOVAL
RHINOPLASTY
SINUS SURGERY (type)
TONSILLECTOMY
THYROIDECTOMY
THYROID LOBECTOMY (which side)
THROAT SURGERY (specify)
PARTIAL THYROIDECTOMY (which side)
UP3/UVULAPALATOPLASTY
ADDITIONAL SURGERIES LIST BELOW:

1.______________________

2.______________________

3.______________________

4.______________________

5.______________________

3.______________________

4.______________________

5.______________________

***IF PATIENT IS A CHILD, WHO DOES PATIENT LIVE WITH? ______________________

____

***DOES *ANYONE* SMOKE *INSIDE OR OUTSIDE* THE HOME OF THE PATIENT *AT ANYTIME* ?
(CIRCLE ONE) YES / NO

***DOES PATIENT ATTEND DAYCARE?
(CIRCLE ONE) YES / NO

____
Patient or Guardian Signature

Name: Date: Front & Back

Respiratory

Asthma. Cough. Coughing Blood. Pain. Short of Breath. Snoring. Tuberculosis.

Cardiovascular

Chest Pain. Heart Murmur. High Blood Pressure. History of Heart Attack.

Gastrointestinal

Liver Disease. Decreased Appetite. Hepatitis. Swallowing Problem. Vomiting Blood.

Musculoskeletal

Arthritis.

Psychiatric

Depression. Excessive Stress.

Neurological

Loss of Consciousness. Strokes.

Endocrine

Cold Intolerance. Goiter. Heat Intolerance. Increased Thirst. Neck Pain. Sweats. Thyroid Trouble. Diabetes.

Hematologic/Lymph

Anemia. Bleeding Easily. Blood Clots. Radiation Exposure.

Urinary

Stones.

PAYMENT AND INSURANCE CONSENT

_______ I hereby authorize Dr. McMillan/Dr. Gillihan/ Dr. Ivey to furnish information to insurance carriers concerning any illness and treatments, and hereby assign to the physicians all payments for medical services rendered to myself or any dependents. I understand that I am responsible for any amount not covered by insurance.

CONSENT FOR TREATMENT

_______ I hereby consent to any necessary medical examination, treatments or testings for myself or for the minor named below for whom i am legally responsible.

Signature (Patient / Parent / Guardian ____________________ Date ____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that i may request in writing that you restrict how my private information is used or dislosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____________________

Relationship to Patient ____________________

Signature ____________________

Date ____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initals	Reason: