(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:_____

→ Turn Da

## 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: |
|---|---|---|
| | | |

NAME: _____

NAME OF PHARMACY _____

ADDRESS _____

PHONE: _____

D.O.B. _____

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 | | |

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

over →

**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: 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.