HEAD AND NECK SURGEONS OF NEW MEXICO, LLC

Name: _____ **SS#** _____ **DOB:** _____

Address: _____ **Home Phone:** _____

City, State: _____ **Zip:** _____ **Cell Phone:** _____

Work Phone: _____

Employer: _____ **Relationship to Patient:** _____

PRIMARY INSURANCE

Primary Insurance: _____ **ID #:** _____**Group #:** _____

Member Name: _____**DOB:** _____ **SS#:** _____

SECONDARY INSURANCE

Primary Insurance: _____ **ID #:** _____**Group #:** _____

Member Name: _____ **DOB:** _____ **SS#:** _____

All professional services rendered are charged to the patient and the patient is financially responsible for all charges. I agree that in the event my insurance company denies payment that I am ultimately responsible for any unpaid balance on my account.
It is the patient's responsibility to provide any referrals required by your insurance company prior to your appointment. It is also the patient's responsibility to verify that we have complied with all of your insurance company's requirements regarding authorization of any testing and/or procedures recommended by any physicians of Head & Neck Surgeons of New Mexico, LLC.

Insurance Authorization and Assignment: I hereby authorize Head & Neck Surgeons of New Mexico, LLC to furnish information concerning my illness and treatment to any physician or hospital whose care I have been under, or whom I may be referred to for additional diagnosis or treatment, and to my insurance carrier to process claims for medical benefits for me and /or my dependents. I hereby assign to Head & Neck surgeons of New Mexico, LLC all insurance payments for services rendered. A photocopy of this authorization may be honored. I consent to photography to be performed, if necessary, as visual data for my medical record and/or teaching purposes.

Signature: _____ **Date:** _____

Chief Complaint:

What problem brings you to the office today? _____

_____

_____

_____

HEAD AND NECK SURGEONS OF NEW MEXICO, LLC

Patient Name _____ **Age** _____ **Date** _____

Have you ever had any of the following:		If yes, please explain in detail:
Anemia	Yes _____ No _____	_____
Arthritis	Yes _____ No _____	_____
Asthma	Yes _____ No _____	_____
Bleeding Disorder	Yes _____ No _____	_____
Blood clots / DVT / PE	Yes _____ No _____	_____
Cancer (including skin & others)	Yes _____ No _____	_____
Cataracts	Yes _____ No _____	_____
Cold sores (fever blister on lip)	Yes _____ No _____	_____
Congestive Heart Failure	Yes _____ No _____	_____
Depression	Yes _____ No _____	_____
Diabetes – Type 1	Yes _____ No _____	_____
Diabetes – Type 2	Yes _____ No _____	_____
Emphysema (COPD)	Yes _____ No _____	_____
Gastric Ulcer	Yes _____ No _____	_____
Gastroesophagal Acid Reflux	Yes _____ No _____	_____
Glaucoma	Yes _____ No _____	_____
Hearing Loss	Yes _____ No _____	_____
Heart Attack	Yes _____ No _____	_____
Heart Disease	Yes _____ No _____	_____
Heart murmur	Yes _____ No _____	_____
Hepatitis	Yes _____ No _____	_____
High Blood Pressure	Yes _____ No _____	_____
Immune Disease, (HIV & others)	Yes _____ No _____	_____
Kidney Failure or Kidney Disease	Yes _____ No _____	_____
Kidney Stones	Yes _____ No _____	_____
Meniere's Disease	Yes _____ No _____	_____
Migraine or Cluster Headache	Yes _____ No _____	_____
Neurologic Disease	Yes _____ No _____	_____
Parotid Cancer	Yes _____ No _____	_____
Pneumonia	Yes _____ No _____	_____
Rheumatoid Arthritis	Yes _____ No _____	_____
Rhinitus, Allergic	Yes _____ No _____	_____
Severe Sinus Infections	Yes _____ No _____	_____
Sinusitis, Chronic	Yes _____ No _____	_____
STD (example, Herpes)	Yes _____ No _____	_____
Stroke or TIA (transient ischemia)	Yes _____ No _____	_____
Thyroid disease	Yes _____ No _____	_____
Thyroid nodule	Yes _____ No _____	_____
Tinnitus (ringing in the ears)	Yes _____ No _____	_____
Tuberculosis or Pulmonary Disease	Yes _____ No _____	_____
Unspecified Liver Disease	Yes _____ No _____	_____

Other (please list):

_____ _____

_____ _____

_____ _____

_____ _____

HEAD AND NECK SURGEONS OF NEW MEXICO, LLC

Patient Name _____ **Age** _____ **Date** _____

Have you ever had surgery of any kind? Please list type and date.

Type of Surgery ☐ Check If None	**Date of Surgery**

Have you ever been hospitalized for a prolonged period? Please list reason and date.

Reason for Hospitalization ☐ Check If None	**Date of Hospitalization**

What medications are you currently taking? (Please include all prescription and non-prescription drugs as well as any herbal, homeopathic or alternative health products)

Prescription Drugs ☐ Check if none	**S**trength (i.e. 50 mg)	**Directions** (such as 2 tablets in the a.m.)	

FOR CLINICAL USE:

Height: ___Ft. ___ In Weight _____

Blood Pressure ____ / ____ Pulse _____

Over the Counter & Non Prescription Drugs ☐ Check if none	**S**trength (i.e. 50 mg)	**Directions** (such as 2 tablets in the a.m.)	

List any allergies to medications or foods

Name of Substance ☐ Check If None	**Type of Reaction**

List any allergies to pollens or environmental allergens

Name of Substance ☐ Check If None	**Type of Reaction**

Please list the present health, or cause of death, of your family member:

Mother
Father
Sister(s)
Brother(s)
Children

Smoking history: ☐ Current ☐ Previous ☐ Never
If you quit smoking, how long ago did you quit? _____

Do you drink alcohol? Yes _____ No _____ If so, how many drinks per week? _____
Have you ever used IV drugs or cocaine? Yes _____ No _____

HEAD AND NECK SURGEONS OF NEW MEXICO, LLC

Patient Name _____ **Age** _____ **Date** _____

Are you currently suffering from any of the following symptoms:

Constitutional

- ○ **Fevers**
- ○ **Chills**
- ○ **Weight loss**

Eyes

- ○ **Double vision**
- ○ **Impaired Vision**
- ○ **Changes in Vision**
- ○ **Redness**

Ears, Nose, Throat

- ○ **Sinus Pain**
- ○ **Nose bleeds**
- ○ **Ear Pain**
- ○ **Ear Discharge**
- ○ **Voice change**
- ○ **Nasal obstruction**
- ○ **Hearing loss**
- ○ **Dry mouth**
- ○ **Difficulty swallowing**
- ○ **Dizziness**
- ○ **Nasal congestion**
- ○ **Sore throat**
- ○ **Tinnitus (ringing in ear)**
- ○ **Neck swelling**
- ○ **Snoring**

Cardiovascular

- ○ **Chest pain**
- ○ **Irregular heart beats**
- ○ **Swelling in legs**

Respiratory

- ○ **Cough**
- ○ **Shortness of breath**
- ○ **Asthma**
- ○ **Wheezing**

Gastrointestinal

- ○ **Heartburn**
- ○ **Nausea**
- ○ **Vomiting**
- ○ **Constipation**
- ○ **Diarrhea**

Neurological

- ○ **Headache**
- ○ **Seizures**
- ○ **Muscular Weakness**
- ○ **Memory difficulties**
- ○ **Tingling or numbness**
- ○ **Loss of consciousness**

Musculoskeletal

- ○ **Muscle pain**
- ○ **Joint pain**

Endocrine

- ○ **Cold Intolerance**
- ○ **Heat Intolerance**
- ○ **Thyroid problems**

Psychiatric

- ○ **Depression**
- ○ **Anxiety**
- ○ **Delusions**

Hematologic/lymphatic

- ○ **Easy bruising**
- ○ **Easy bleeding**
- ○ **Swollen or tender lymph nodes**

Allergic/Immunologic

- ○ **Allergic dermatitis**
- ○ **Seasonal allergies**
- ○ **Anaphylaxis**

Our Tijeras office is located at:

1020 Tijeras Ave. NE #22
Albuquerque, NM 87106
505-848-3124 office
505-848-8077 fax

Directions:

From I-25

Take the Dr. Martin Luther King exit and head east on Dr. Martin Luther King. Travel 2 streets east and turn right (south) on Mulberry. Turn right on Tijeras and make an immediate left into our parking lot. Our office is located upstairs to the right.

From University

Head west on Dr. Martin Luther King. Two blocks BEFORE you reach the freeway, turn left on Mulberry. Make a right on Tijeras and an immediate left into our parking lot. Our office is located upstairs to the right.
