

Patient Information



Scott N Bateman, M.D.

Sinus - Allergy - Facial Plastic Surgery
Otolaryngology - Head & Neck Surgery

330 W. Dow, Sheridan, Wyoming

(307)672-0290

PRIMARY PHYSICIAN						
PATIENT'S NAME		PREFERRED NAME	SEX M F	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS			CITY, STATE, AND ZIP CODE			HOME PHONE NUMBER
PATIENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT) HOW LONG EMPLOYED			BUSINESS PHONE NUMBER
EMPLOYER STREET ADDRESS			CITY, STATE AND ZIP CODE			CELL PHONE NUMBER
IN CASE OF EMERGENCY CONTACT- NAME, PHONE AND ADDRESS						
SPOUSE'S NAME						
SPOUSE'S EMPLOYER			SPOUSE'S OCCUPATION (INDICATE IF STUDENT)			BUSINESS PHONE NUMBER
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE
HOW DID YOU HEAR ABOUT THIS PRACTICE? (CHECK ALL THAT APPLY)						
<input type="checkbox"/> ANOTHER PATIENT		<input type="checkbox"/> PREFERRED BY A PHYSICIAN		<input type="checkbox"/> WORD OF MOUTH		<input type="checkbox"/> OTHER - SPECIFY:
				<input type="checkbox"/> YELLOW PAGES: QWEST (LARGE DIRECTORY)		<input type="checkbox"/> YELLOW PAGES: SHERIDAN & JOHNSON (SMALL DIRECTORY)

If the Patient is a Minor or Student:

MOTHER'S NAME		SOCIAL SECURITY NO	STREET ADDRESS CITY STATE AND ZIP CODE		HOME PHONE NO
MOTHER'S EMPLOYER		OCCUPATION		HOW LONG EMP	BUS. PHONE NO
EMPLOYER'S ADDRESS		CITY AND STATE			ZIP CODE
FATHER'S NAME		SOCIAL SECURITY NO	STREET ADDRESS CITY STATE AND ZIP CODE		HOME PHONE NO
FATHER'S EMPLOYER		OCCUPATION		HOW LONG EMP	BUS. PHONE NO
EMPLOYER'S ADDRESS		CITY AND STATE			ZIP CODE

All professional services rendered are charged to the patient. In order to control our cost of billing, we request that services be paid for at the time they are rendered. We would rather control our billing cost than be compelled to raise our fees.

Insurance Information:

PERSON RESPONSIBLE FOR PAYMENT		STREET ADDRESS CITY, STATE AND ZIP CODE		HOME PHONE NO
COMPANY NAME AND ADDRESS	NAME OF POLICY HOLDER		POLICY NO	GROUP NO
COMPANY NAME AND ADDRESS	NAME OF POLICY HOLDER		POLICY NO	GROUP NO
COMPANY NAME AND ADDRESS	NAME OF POLICY HOLDER		POLICY NO	GROUP NO

Insurance Authorization and Assignment:

I hereby authorize Scott N Bateman M.D., Sheridan Ear Nose & Throat and/or their authorized agents to furnish information to insurance carriers concerning this condition/illness/accident and treatments and hereby irrevocably assign to Dr. Bateman all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for all charges, whether or not covered by insurance.

SIGNATURE OF RESPONSIBLE PARTY

DATE



Confidential Patient Visit

Adult

Sheridan Ear, Nose & Throat

330 W. Dow, Sheridan WY 82801 (307) 672-0290

Today's Date _____

Patient's Name: _____
Last First Middle Age

Reason for Today's Visit: _____

Did another physician request that you see Dr. Bateman? YES NO _____ Their name

Past Medical History

What illnesses have you had or do you now have?

- | | | | |
|--|---|---|--|
| Cancer..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies/Hay fever..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Bleeding / Bruising.... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease/Hepatitis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid problems..... <input type="checkbox"/> YES <input type="checkbox"/> NO | AIDS / HIV..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney/Bladder Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Hearing loss/ringing.... <input type="checkbox"/> YES <input type="checkbox"/> NO | Mental Illness..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy / Seizure..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinusitis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Other..... <input type="checkbox"/> YES <input type="checkbox"/> NO |

If yes, please list details and dates here: _____

Past Surgical History

What surgery or injuries have you had?

- | | | | |
|---|--|---|---|
| Gallbladder..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Tonsils..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus Surgery..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Breast Surgery..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Appendix..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Adenoids..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Surgery..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Pregnancy..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Abdomen / Belly..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Nose surgery..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Throat / Neck..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Caesarian Section..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Accident / Fracture..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Ear surgery..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Sterilization..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Other..... <input type="checkbox"/> YES <input type="checkbox"/> NO |

If yes, please list details and dates here: _____

Family History

Do members of your family suffer from these conditions?

- | | | | |
|--|---|---|--|
| Cancer..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies/Hay fever..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Bleeding / Bruising.... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease/Hepatitis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid problems..... <input type="checkbox"/> YES <input type="checkbox"/> NO | AIDS / HIV..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney/Bladder Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Hearing loss/ringing.... <input type="checkbox"/> YES <input type="checkbox"/> NO | Mental Illness..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy / Seizure..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinusitis..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Other..... <input type="checkbox"/> YES <input type="checkbox"/> NO |

If yes, please list details and dates here: _____

Lifestyle Married, live with spouse Married, live apart from spouse Single Widow(er) Divorced Separated

Employed? YES NO Occupation _____ Parent of how many children? _____

Tobacco Use I have never used tobacco I quit _____ ago; I smoked _____ packs per day for _____ years

I use smokeless tobacco I smoke _____ cigarettes / packs per day; I have smoked for _____ years

Alcohol Use Never drink alcohol Occasional social drink Drink every week Drink every day

Drug Use?..... YES NO Unprotected sex with more than one partner in last ten years?..... YES NO

If yes, please list details and dates here: _____

Medications

Please list any medications you may be taking and their dosages

Are you **allergic** to any medications? YES NO

If yes, please list them here: _____

General Consent for Treatment

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Dr. Bateman, his assistants or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Bateman.

Patient's or Responsible Party's Signature

Date

