Richard W. Quisling, M.D.
Susannah Q. Longmuir, MD

New Patient Registration Information

Date:_____

Patient Name_____ DOB_____ Age_____ Sex: M F

Address_____ City_____ State_____ Zip:_____

Home phone_____ Cell Phone: _____ E-mail_____

Marital Status: _____ SS # _____

Patient Employment Information:

Place of Employment_____

Address_____ City_____ State_____

Phone_____ ext._____ Occupation_____

If married or a minor, please answer the following:

Spouse or Parent's Name_____

Spouse or Parent's SS#_____ Date of Birth_____

Emergency Contact_____ Phone_____

Name of Referring Doctor, if any _____

Who is responsible for the bill? _____

Insurance Information: Please provide a copy of Insurance Card(s) (front and back)

I, the undersigned, authorize the release of any medical information necessary to treat me or to process the claim for services. I ask and agree that the benefits due me for my treatment be paid or assigned to the above named entities. I am responsible for any costs not covered for any reason, by my benefits, including deductibles, co-insurance and co-pays. This office will process your Primary and Secondary insurance claim, if correct information is provided.

Sign_____ date_____

I, the undersigned, understand that the above named entities will test or treat me as needed. No guarantees are made or implied regarding my treatments or the results. All the information I have provided to this office is correct. I also give permission to email, text or call me with updates to my bill or appointments.

Sign_____ date_____

Return Fax: 615-885-4719 *Include Copy of Insurance Card. (Front and Back)

Name:_____Age_____Date:_____

What is the main reason you came to see the doctor today?_____

How long have you been suffering with this?_____

Have you seen another doctor for this condition?_____If YES, whom did you see and when?_____

_____

Are you employed? Yes No If yes, what is your occupation? _____

Past Medical History:

1. Have you surgery on your eyes, ears, nose, or throat? Yes No
2. Circle the following surgeries you have had? Tonsillectomy Adenoidectomy T&A

   Nasal sinus surgery Thyroid surgery Cataract surgery Wisdom teeth removal

   Ear surgery/tubes Eye muscle surgery Retinal surgery Laser eye surgery

Are you allergic to any medications? Yes No (if yes, list the medications to which you are allergic)

_____ _____

_____ _____

What medications are you currently taking? _____

_____ _____

_____ _____

Do you smoke? _____ Do you drink alcohol? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE:

Diabetes Heart disease High Blood Pressure Kidney disease AsthmaLung disease

Stomach trouble Thyroid disease Anemia Lupus Bleeding disorder Cancer

Do you have excessive bleeding after surgery? Yes No

Are you on blood thinners, such as aspirin, Aleve, Ibuprofen, or heparin? Yes No

Do you see a chiropractor for neck, shoulder, or back pain? Yes No

1. Regarding your **EARS,** do you have the following complaints?

Ear Pain? Yes No
Ear drainage? Yes No
Itching of the Ears? Yes No
Sensation of swelling/fullness/ blockage of the ears? Yes No
Difficulty hearing? Yes No
More than 4 infections of the ear in the last 6 months? Yes No

Pain when you move your jaw? Yes No
Tenderness in front of the ears? Yes No
Pain front of your ears? Yes No
Pain in the area of your temples? Yes No

Ringing in the ears? Yes No
Clicking or popping your ears? Yes No
Dizziness? Yes No
Sensation that the room is Spinning? Yes No

2. Regarding your NOSE do you have any of the following complaints?

blockage? Yes No
stuffiness? Yes No
frequent colds? Yes No
itchy nose? Yes No
bad odor in the nose? Yes No
sensation of pain or tightness in the nose? Yes No

dryness of the nose? Yes No
nosebleeds? Hay Yes No
fever? Yes No
attacks of sneezing? Yes No

3. Regarding your **EYES,** do you have any of the following complaints?

Blurry Vision? Yes No
Itching of the eyes? Yes No
Burning of the eyes? Yes No
Dryness of the eyes? Yes No
Pain in the eyes? Yes No
Swelling of the eyes? Yes No
Changes in vision? Yes No Loss of vision? Yes No
Double vision? Yes No
Redness of the eyes? Yes No
Eye Drainage? Yes No

4. Regarding your **MOUTH** and **THROAT,** do you have any of the following complaints?

Dripping from the back of the nose into the throat? Yes No
Do you use a CPAP or sleep devices? Yes No
Did it cure you? Yes No
Frequent sore throats? Yes No
Dryness of the throat? Yes No
Itching/tickling of the throat? Yes No
Difficulty swallowing? Yes No
Bad teeth/bleeding gums? Yes No
Hoarseness of voice changes? Yes No
Necessity of clearing and throat often? Yes No
Do you have trouble with mouth lesions? Yes No

Have you ever taken allergy shots? Yes No If yes, did they help? Yes No

Have you ever had a CT of the head, sinuses, or throat? Yes No

If yes, where and when?_____

Have you ever had a MRI of the orbits, head, sinuses, or throat? Yes No

If yes, where and when?_____

5. Regarding your lungs and Breathing?

Do you have asthma? Yes No
Do you have shortness of breath? Yes No
Do you have painful breathing? Yes No
Do you have wheezing? Yes No
Do you cough up sputum or mucous when you cough? Yes No
Is what you cough up discolored or bloody? Yes No
Do you cough frequently? Yes No

6. Regarding your heart and Circulatory system:

Do you have chest pain? Yes No
Do you have shortness of breath when lying flat? Yes No
Do you have heart flutters or irregular heart beat? Yes No

Do you have edema or swelling in your legs or hands? Yes No
Do you have excessive urination at night? Yes No
Do you have varicose veins Yes No

7. Neurological:

Do you have weakness in parts of your body? Yes No
Do you have headaches Yes No
If yes:
Is your headache usually on side of your head? Yes No
Does it begin in or about your eyes? Tus

Circle all the symptoms that you have with your headaches?

visual problems nausea vomiting throbbing pain
Sensitivity to light
Neck pain and stiffness in the neck

Is your headache usually on one side both sides

8.Regarding your skeletal system?

Do you have joint pain or stiffness? Yes No
Muscle pain or strain in

the neck? Yes No
Stiff Neck? Yes No
Bones aches or pains? Yes No
Do you have muscle weakness? Yes No
Back pain? Yes No

9. Regarding your skin:

Do you have unusual hair loss or breakage? Yes No

Do you have blackouts? Yes No
Do you have seizures? Yes No Do you have loss of memory? Yes No
Do you have mood swings? Yes No
Do you have hallucinations? Yes No

Do you have excessive urination? Y N
Do you have lessened urination? Y N Do you have cloudy or dark urine? Yes No
Do you have flank (side) pain? Y N Do you have urinary incontinence? Y N Do you have blood in your urine? Y N

10. Regarding your endocrine system:
Do you suffer more in the cold

or in the heat? Heat Cold
Do you suffer from excessive Sweating? Yes No

Do you have a rapid heart rate? Yes No
Do you have hair loss or hair?

Yes No
Do you have very dry skin?
Yes No

Do you have difficulty swallowing
Yes No
Do you have excessive thirst?
Yes No

Do you have excessive hunger?
Yes No

11. Regarding your stomach and bowels:
Circle any of the following that you have:

Stomach trouble
Ulcers
Heartburn
Do you have rectal bleeding?
Yes No
Hemorrhoids? Yes No
Rectal pain? Yes No

12. Have you ever tested positive for any of the following?
Tuberculosis HIV or AIDS

Hepatitis A Hepatitis B Hepatitis C
Ifso, were you treated? Yes No

13. Circle any of the following that you presently suffer from:

fatigue swollen glands
sore throat fevers (low/high)
headache insomnia depression

tearfulness nervousness
loss of concentration worry
back pain chest pain joint pain
pain in arms or legs

weakness gas dizziness
anxiety suicidal thoughts

Rectal fissures? Yes No

14. Regarding sleep: Please circle all the following that you have:

sleeplessness choking when asleep snoring waking up gasping coughing during sleep

Do you wake up early and are unable to go back to sleep? Yes No

15. Do you use recreational drugs? Yes No

16. Regarding your Genitourinary System:
Do you have painful urination? Yes No

FAMILY HISTORY? Circle any of the following diseases that any of your family members may have:

Asthma
Bleeding disorders
Cancer- Breast
Cancer-Uterine/ ovarian
Cancer-colon
Cancer-throat
Cancer – other
Diabetes
Hearing problems
Heart Disease
High blood pressure
Blindness
Strabismus – eye muscle alignment
Thyroid cancer or disease
Neurofibromatosis
Anesthesia complications

HOW DID YOU HEAR ABOUT US?
Circle

Google
Internet other
Referred by a doctor
Referred by a friend or family member
Other_____

RICHARD W. QUISLING, M.D., P.C.
Richard W. Quisling, M.D.
SUSANNAH QUISLING LONGMUIR, M.D., P.C.
Susannah Quisling Longmuir, M.D.

ATTENTION: OFFICE POLICY REGARDING EMERGENCY CARE AND/OR TREATMENT

The doctor patient relationship for the offices of Richard W. Quisling, M.D., P.C. (Richard W. Quisling, M.D.) and/or Susannah Quisling Longmuir, M.D., P.C. (Susannah Quisling Longmuir, M.D.) does not provide total coverage after hours and weekends or Holidays for emergency treatment and in situations where the informed consent for the most effective form of treatment would include tertiary/hospital, hospitals, or emergency care. Dr. Quisling provides a family practice type otolaryngology/ENT service and Dr. Longmuir provides a family practice type ophthalmology service. The care of these doctors is limited to treating medically with minor surgical procedures and/or vocal care and treatment of eye disease and discomfort. If you feel you have a medical emergency, call 911 or go to the nearest Emergency Room. Both Dr. Quisling and Dr. Longmuir can be reached through their answering service but neither ENT nor EYE coverage can be guaranteed for emergencies.

I have read, understand, and accept the above statement and realize that in the event I feel that I have a medical emergency, it is my responsibility to seek emergency advice and care in a hospital emergency room or clinic. I will not hold either Dr. Quisling or Dr. Longmuir responsible for any outcome in my regard due to my inability to reach him or her should that be the case.

Signature of patient_____date_____

Print name_____

Signature of witness_____ date_____

Richard W. Quisling, M.D. & Richard W. Quisling, M.D.,P.C.
Susannah Q. Longmuir, M.D. & Susannah Quisling Longmuir, M.D., P.C.

Consent for Treatment

I, _____ understand and agree that Richard W. Quisling, M.D. and Richard W. Quisling, M.D., P.C. and/or Susannah Q. Longmuir, M.D., and Susannah Q. Longmuir, M.D., P.C. may test or treat me as needed.

I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do so refuse. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. No guarantees were made to me about the results of my treatment.

If I have questions or concerns about any of the above, I will speak with the doctor (s) before care is provided.

Agreement to Pay: By signing this document, I agree that: All the information I have given you is correct. The doctor may release or share any information needed to process my claims. Those providing my care shall be paid or assigned benefits on my behalf. I will co-operate with and provide documentation requested by my insurance company or other payer necessary to process my claims. I am responsible for any costs not covered by my benefits, including non-covered services, deductibles, and co-insurance, and co-pays.

Please Note: by signing this agreement, I understand that I may see either doctor herein named, but that it is not necessary that I see both doctors. I realize that, while the doctors may share a waiting room, that each is a separate medical office with separate business systems and separate billing. I am responsible for my co-pays and deductibles as billed by the treating doctor individually. The treating doctor will be identified on my bill or my insurance form as the treating doctor the rendering doctor and as the billing doctor.

Assignments of Benefits: If Dr. Quisling or Dr. Longmuir is in position to accept my insurance, I ask and agree that any benefits due to me for my treatment by all insurance companies or other third party payers responsible for my care shall be paid or assigned to the billing doctor. This includes any settlements related to the reason for my treatment. These benefits shall not be more that the charges for my treatment. If my insurance company or other payer will not pay the doctor directly for my care and treatment, I will immediately forward payments I receive to my doctor, Dr. Quisling or my doctor, Dr. Longmuir.

Non-covered services: I understand that my insurance or payer may not cover all my costs. I agree that I am personally responsible for any costs not covered by my insurance or payer.

Guarantor Agreement: I, or the person signing or guaranteeing payment for me or my child, am responsible for any charges not covered by my insurance, for any reason. Such charges are due when my treatment is stopped or I am discharged. I understand that I may not receive a bill and realize that it is my responsibility to check with the office of the doctor to see if I have any current or past due amounts owed. The doctors or their offices may also may bill my insurance for me. But either doctor or his or her office may also ask for payment in full, in advance, unless the doctor agrees with my insurance company or other payer not to do so.

I understand and agree that the above applies to any minor child I may have or have custody of, who is being treated by Richard W. Quisling, M.D. or Susannah Q. Longmuir, M.D. or their individual offices.

Signed_____ date_____

Relationship to patient: Self or Guarantor: _____

Richard W. Quisling, M.D. & Richard W. Quisling, M.D., P.C.
Susannah Q. Longmuir, M.D. & Susannah Quisling Longmuir, M.D., P.C.

I hereby give my consent for Dr. Quisling and/or Dr. Longmuir to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The doctors herein named reserves the right to revise their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Quisling or Dr. Longmuir.

With this consent, Dr. Quisling or Dr. Longmuir and their respective office staff, may call my home or other alternative location and leave a message on my voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Quisling and/or Dr. Longmuir may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. Quisling and Dr. Longmuir may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Dr. Quisling or Dr. Longmuir restrict how they use or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Quisling or Dr. Longmuir to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Quisling and/or Dr. Longmuir may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

Patient's full name_____ Date_____

Print name of patient or legal guardian, if applicable_____