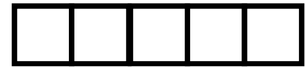
Ear Nose Throat & Sinus SPECIALISTS



NEW PATIENT REGISTRATION FORM

rev 051611

PATIENT First Name ______________________ Last Name ______________________ DOB____ ____/____ ____/____ ____ Age____ ____

Address ______________________________ City ______________ Zip ________ Phone (___ ___ ___)___ ___ ___ - ___ ___ ___ ___

Single ☐ Married ☐ Widowed/Divorced ☐ Full-Time Student ☐ Occupation ______________________________

Employer (Parent's Employer if Patient is a Child) __________________ Address ______________City __________ Zip ________

INSURANCE As a service to you, we will bill your insurance company for your benefits on your behalf. To do so we will require the following information:

What is the patient's relationship to the Primary Insured Person? Self ☐ (if Self skip to Medical Section) Child ☐ Spouse ☐

Primary Insured Person's First Name __________________ Last Name ______________________ DOB____ ____/____ ____/____ ____

Primary Insured Person's Employer______________________ Address __________________ City __________ Zip ________

MEDICAL Who referred you? ____________ Who is your regular MD? ______________ Who is your Cardiologist (if have one)? ____________

What is the medical problem that they referred you to us for?____

Are you ALLERGIC to any medications? No ☐ if Yes, list____

Are you TAKING any medications? No ☐ if Yes, list______________________________________ See Attached List ☐

Has any of your Close Blood Relatives had Heart Problems, Strokes, Cancer, Bleeding or ENT Problems? No ☐ if Yes, explain____________________

Have you ever Smoked regularly? No ☐ if Yes, I started at age _______ if Quit, age quit _______

Have you ever Drank more than 3 alcoholic drinks/day regularly? No ☐ if Yes, I started at age _______ if Quit, age quit _______

Have you ever used Drugs regularly? No ☐ if Yes, I started at age _______ if Quit, age quit _______

REVIEW Have you had recent: Unexplained Weight Loss ☐ Night Sweats ☐ High Fevers ☐ Severe Fatigue ☐ if Yes, explain__________ No ☐

Do you have: Cataracts ☐ Glaucoma ☐ recent Double Vision ☐ other Eye Problems ☐ if Yes, explain ________________ No ☐

Have you ever had Ear, Nose, Throat, Sinus, Face, or Neck: Injury ☐ Surgery ☐ Bad Scars ☐ if Yes, explain________________ No ☐

Do you have: High Blood Pressure ☐ High Cholesterol ☐ Heart Problems ☐ Blood Vessel Problems ☐ if Yes, explain____________ No ☐

Do you have: Asthma ☐ Chronic Cough ☐ Lung Disease ☐ Breathing Problems ☐ if Yes, explain________________ No ☐

Do you have: Acid Reflux/Heartburn ☐ Stomach Problems ☐ Liver Problems ☐ Intestinal Problems ☐ if Yes, explain____________ No ☐

Have you ever had: Seizures ☐ Stroke ☐ Depression ☐ Dementia ☐ other Nerve Problems ☐ if Yes, explain____________ No ☐

Do you have: Diabetes ☐ Obesity ☐ Thyroid Problems ☐ other Gland Problems ☐ if Yes, explain________________ No ☐

Do you have: Lymphatic Problems ☐ Anemia ☐ Bleeding Problems ☐ other Blood Problems ☐ if Yes, explain____________ No ☐

Have you ever had: Tumor ☐ Cancer ☐ Radiation ☐ Chemotherapy ☐ Immune Problems ☐ if Yes, explain ____________ No ☐

MD Reviewed ☐

By signing below as the Responsible Person you agree; (1) that any co-payments, co-insurance, or deductibles that your insurance company requires us to collect from you are due at the time you or your child receives medical services, (2) to have your insurance benefits paid directly to us, (3) that you remain ultimately responsible for all bills that are not paid directly to us by your insurance company, (4) to authorize us to acquire and release medical and financial information required for appropriate medical and financial reasons only, (5) that should a disagreement about any of the medical services we provide occur, you will resolve them by neutral arbitration under California law, rather than exercising your right to a trial with a judge or jury, as detailed in our current *Notice of Disagreement Practices*, (6) that we will protect your confidential information according to our current *Notice of Privacy Practices*, (7) to request a copy of either notice prior to signing this registration if you have questions.

Signature of Responsible Person ______________________ Date ____ ____/____ ____/____ ____