Ear Nose Throat & Sinus SPECIALISTS

NEW PATIENT REGISTRATION FORM

rev 082009

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 to us?** ______________________ **Who is your regular Doctor? (if different from who referred you)** _________________________

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** ____ ____/____ ____/____ ____