

**Ear, Nose & Throat**  
Associates of Southeastern CT, P.C.

**PATIENT REGISTRATION**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 NAME OF PARENTS (if patient is a minor) \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE: (    ) \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 EMERGENCY CONTACT \_\_\_\_\_ PH# (    ) \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_  
 PERSON COMPLETING FORM (if different) \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

**INSURANCE INFORMATION (MUST BE COMPLETED)**

PRIMARY INS CO. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
 NAME OF POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 SECONDARY INS CO. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
 NAME OF POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

**HIPPA COMPLIANCE/CONTACT INFO (Carolyn Howell, Practice Manager/HIPPA Officer (860) 442-0407 ext. 213)**

\*\* I acknowledge receiving Ear, Nose and Throat Associates of Southeastern Connecticut's Privacy Notice. \_\_\_\_\_ (initial)  
 \*\*I consent to allow Ear, Nose and Throat Associates of Southeastern Connecticut, P.C. to contact me and leave messages, including test results and appointment confirmations, in the following manner (check all that apply), please note written communication may require a fee:

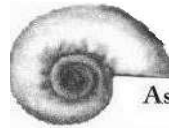
- |   |  |
|---|--|
| <input type="checkbox"/> home (    ) _____                          | <input type="checkbox"/> email: _____                        |
| <input type="checkbox"/> work (    ) _____                          | <input type="checkbox"/> cell (    ) _____                   |
| <input type="checkbox"/> You may leave messages with family members | <input type="checkbox"/> You may only speak to me personally |

**PERSONAL REPRESENTATIVE**

Please list the name(s) of anyone you designate as your personal representative. This will allow our office staff and to discuss your protected health information with these individuals. You will be required to inform us, in writing, if you chose to delete an individual from this list.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Past Medical, Social & Family History**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status:  S  M  W  D

**Female only:** Is there a chance you may be pregnant?  No  Yes Last menstrual period \_\_\_\_\_

Do you have a living will?  No  Yes

Name of Health Care representative (if applicable): \_\_\_\_\_

**PAST MEDICAL HISTORY/SYSTEM REVIEW**

Check off if you ever had any of these conditions : (unchecked box implies you NEVER have had the condition)

- Asthma       COPD/Emphysema       Heart Disease       High Blood Pressure       Strokes       Arthritis
- Diabetes       Thyroid Disease       HIV/AIDS       Lupus       Seizures       GERD
- Hiatal Hernia       Irritable Bowel       Hepatitis       Enlarged Prostate       Kidney Stones       Urinary Prob
- Pancreatitis       Glaucoma       Cataracts       Depression/Anxiety       Psychosis       Sleep Apnea
- Migraines       Peptic Ulcers       Other \_\_\_\_\_
- Cancer (Type): \_\_\_\_\_

None of the above

**Past Hospitalizations/Surgeries and Dates:**


**SOCIAL HISTORY**

- Alcohol - Type \_\_\_\_\_ Amount per week \_\_\_\_\_
- Cigarettes - Packs per day \_\_\_\_\_ Years smoking \_\_\_\_\_ Year quit \_\_\_\_\_
- Coffee/Tea - Cups per day \_\_\_\_\_
- Soda - Type/Amount per day \_\_\_\_\_
- Have you ever been treated for alcohol or substance abuse?  No  Yes

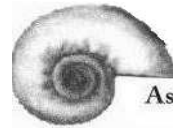
**FAMILY HISTORY** (Please describe your relationship to affected family members)

- Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Asthma \_\_\_\_\_
- Stroke \_\_\_\_\_  Thyroid \_\_\_\_\_  High Blood Pressure \_\_\_\_\_
- Bleeding Problems \_\_\_\_\_  Hearing Loss \_\_\_\_\_  Problems with Anesthesia \_\_\_\_\_
- Cancer (Type) \_\_\_\_\_

I certify that information is true and correct to the best of my knowledge.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by:
RAG <u>DSB</u>
FGM    FRD



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICATIONS AND ALLERGIES**

Pharmacy: \_\_\_\_\_ Town: \_\_\_\_\_

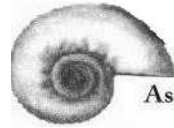
**PLEASE LIST YOUR CURRENT MEDICATIONS.** Please include herbal supplements, vitamins, Aspirin, Tylenol, Advil/Motrin and over-the-counter medications. **IT IS VERY IMPORTANT THAT YOU LET YOUR DOCTOR KNOW IF ANY OF THE FOLLOWING SUPPLEMENTS ARE USED: Echinacea, Metabolife or similar product, Garlic, Gingko, Ginseng, Kava, St. John's Wart, Valerian.**

Medication	Dose	Frequency	Medication	Dose	Frequency

**ALLERGIES: Do you have any MEDICATION allergies?**     No     Yes  
**IF YES, PLEASE LIST:**  
  
Do you have an allergy to Latex?     No     Yes

I certify that information is true and correct to the best of my knowledge.  
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by:  
RAG    FRD  
FGM    DSB



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**REVIEW OF SYSTEMS (Do you currently have any of the following complaints-please check off):**

**GENERAL (Constitutional/endocrine/heme)**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> chronic fatigue        | <input type="checkbox"/> weight loss    | <input type="checkbox"/> excessive urination     | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> weight gain            | <input type="checkbox"/> fever          | <input type="checkbox"/> intolerance of hot/cold |  |
| <input type="checkbox"/> easy bruising/bleeding | <input type="checkbox"/> swollen glands | <input type="checkbox"/> anemia                  |  |

**EARS, EYES, NOSE, THROAT**

- |   |   |                                      |  |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> ringing in the ear | <input type="checkbox"/> sinus complaints | <input type="checkbox"/> sore throat | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> ear infections     | <input type="checkbox"/> hearing loss     | <input type="checkbox"/> hoarseness  |  |
| <input type="checkbox"/> poor vision        | <input type="checkbox"/> blurring         |                                      |  |

**LUNGS**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> short of breath | <input type="checkbox"/> pneumonia         | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> cough           | <input type="checkbox"/> asthma/bronchitis |  |

**HEART**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> chest pain           | <input type="checkbox"/> palpitations | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> blood clots  |  |

**SKIN (skin, allergy, immune)**

- |                                    |                                   |  |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> rashes    | <input type="checkbox"/> dry skin | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> hay fever | <input type="checkbox"/> hives    |  |

**GASTROINTESTINAL**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> heartburn      | <input type="checkbox"/> diarrhea        | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> constipation   | <input type="checkbox"/> nausea/vomiting |  |
| <input type="checkbox"/> blood in stool | <input type="checkbox"/> liver disease   |  |

**URINARY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> kidney stones  | <input type="checkbox"/> urinary infections | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> renal disease      |  |

**MUSCULOSKELETAL**

- |                                    |                                       |  |
|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> chronic pain | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> gout      | <input type="checkbox"/> muscle aches |  |

**NEURO/PSYCH**

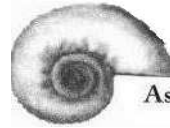
- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> stroke            | <input type="checkbox"/> tremor    | <input type="checkbox"/> memory loss        | <input type="checkbox"/> NO COMPLAINTS |
| <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> migraine  | <input type="checkbox"/> depression/anxiety |  |
| <input type="checkbox"/> panic             | <input type="checkbox"/> headaches | <input type="checkbox"/> seizures           |  |

**I certify that information is true and correct to the best of my knowledge.**

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Reviewed by:	
RAG	DSB
FGM	FRD



**Ear, Nose & Throat**

Associates of Southeastern CT, P.C.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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#### FINANCIAL POLICY

We will gladly bill your insurance for services rendered, we do this as a courtesy to our patients. However, to do so, we must have all the insurance information provided to us before services are rendered or payment in full is required. We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc., other than to supply factual information as necessary. *It is crucial you are aware of your insurance benefits*. If your services are denied due to a "non-covered benefit", or for medical necessity, time restrictions or failure to get a referral for your visit you are responsible for the timely payment of your services. We participate with the following insurances (subject to change): Medicare, CT Blue Cross, Federal Blue Cross, Healthnet, United Healthcare, Title 19, Colonial Co-op, Taft Hartly, Med Span, Cigna. I also request that payment of authorized benefits be made in my behalf to Ear, Nose and Throat Associates of Southeastern Connecticut, P.C. for any services furnished to me.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE THAT ENT ASSOCIATES MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES RELATED TO MY MEDICAL TREATMENT.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_