EAR NOSE & THROAT
ASSOCIATES OF SECT

PATIENT REGISTRATION

PATIENT NAME: ______________________ DOB: ______________ SS#: ______________

NAME OF PARENTS (if patient is a minor) ______________________________

HOME ADDRESS ______________________________ HOME PHONE: ______________

CITY: ______________ STATE: ________ ZIP: ____________ CELL PHONE: ______________

MAILING ADDRESS (if different) ______________________________

CITY: ______________ STATE: ________ ZIP: ____________

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#:______________

RACE/ETHNICITY/PREFERRED LANGUAGE

Race (choose one): ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Unknown ☐ Refuse to answer

Ethnicity (choose one): ☐ Hispanic origin ☐ Non-Hispanic origin ☐ Unknown ☐ Refuse to answer

Preferred Language: ______________________________

**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:

Text Appointment Reminders? ☐ Yes ☐ No Cell#	Email Appointment Reminders? ☐ Yes ☐ No email:	Telephone Appointment Reminders? ☐ Yes ☐ No Preferred#:

May we leave test results and/or discuss your medical condition with family members? ☐ YES ☐ NO

PERSONAL REPRESENTATIVE

Please list the name(s) of anyone you designate as your personal representative to discuss protected health information if required.

Name(s):

______________________________ ______________________________

______________________________ ______________________________

SIGNATURE______________________________ **DATE**______________

Name:_______________

DOB: _______________

EAR NOSE & THROAT
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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**___________________

Name: ______________

DOB: ______________

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

GENERAL (Constitutional/endocrine/heme)

☐ chronic fatigue ☐ weight loss ☐ excessive urination ☐ NO COMPLAINTS
☐ weight gain ☐ fever ☐ intolerance of hot/cold
☐ easy bruising/bleeding ☐ swollen glands ☐ anemia

EARS, EYES, NOSE, THROAT

☐ ringing in the ear ☐ sinus complaints ☐ sore throat ☐ NO COMPLAINTS
☐ ear infections ☐ hearing loss ☐ hoarseness
☐ poor vision ☐ blurring

LUNGS

☐ short of breath ☐ pneumonia ☐ NO COMPLAINTS
☐ cough ☐ asthma/bronchitis

HEART

☐ chest pain ☐ palpitations ☐ NO COMPLAINTS
☐ irregular heart beat ☐ blood clots

SKIN (skin, allergy, immune)

☐ rashes ☐ dry skin ☐ NO COMPLAINTS
☐ hay fever ☐ hives

GASTROINTESTINAL

☐ heartburn ☐ diarrhea ☐ NO COMPLAINTS
☐ constipation ☐ nausea/vomiting
☐ blood in stool ☐ liver disease

URINARY

☐ kidney stones ☐ urinary infections ☐ NO COMPLAINTS
☐ blood in urine ☐ renal disease

MUSCULOSKELETAL

☐ arthritis ☐ chronic pain ☐ NO COMPLAINTS
☐ gout ☐ muscle aches

NEURO/PSYCH

☐ stroke ☐ tremor ☐ memory loss ☐ NO COMPLAINTS
☐ numbness/tingling ☐ migraine ☐ depression/anxiety
☐ panic ☐ headaches ☐ seizures

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

Patient's Signature____**Date**____________________________

Name:_____________

Date: _____________ DOB:_________________

EAR NOSE & THROAT ASSOCIATES OF SECT

WATERFORD 19 46 MYSTIC

MEDICATIONS AND ALLERGIES

Pharmacy:____________________________ **Town:**__________________________________

PLEASE LIST YOUR CURRENT MEDICATIONS. Please include herbal supplements, vitamins and over-the-counter medications.

Medication	Dose	Frequency	Reason

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**_________________

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Patient's Signature____ **Date**_________________

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Patient's Signature____ **Date**_________________

Patient's Signature____ **Date**_________________

Patient's Signature____ **Date**_________________

Patient's Signature____ **Date**_________________

Patient's Signature____ **Date**_________________

Patient's Signature____ **Date**_________________

Name: ___________________________________

DOB: ___________________________________

EAR NOSE & THROAT
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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, Aetna, Connecticare, 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. In the event my account is referred to an attorney or collection agency for collection I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees wouldl only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.

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 INCLUDING THE DOWNLOAD OF DIGITAL INFORMATION FROM PHARMACIES OR THIRD PART PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES RELATED TO MY MEDICAL TREATMENT.

SIGNATURE___________________________ **DATE**__________________

OFFICE PROCEDURES POLICY

Please know that some commonly performed parts of your ENT examination in this office MAY include Mirror Examinations of the Vocal Cords/ larynx and/or nasopharynx, and/or FIBEROPTIC EXAMINATIONS of the nose and or larynx/vocal cords. If such a procedure is performed a procedural fee will be submitted to your insurance carrier. You should know that YOUR INSURANCE CARRIER may refer to these routine parts of your specialist's consultation as PROCEDURES or even SURGICAL PROCEDURES. If our office participates with your insurance carrier you will only be obligated to pay for any deductibles, co-insurance and/or co-pays as agreed upon by you and your carrier. Please know that the performance of these procedures by your specialist is to give you the most accurate and best care available. PLEASE SIGN TO ACKNOWLEDGE YOUR UNDERSTANDING OF THIS POLICY SO THAT YOUR PHYSICIAN MAY PROCEED WITH A PROCEDURE IF IT IS INDICATED.

SIGNATURE___________________________ **DATE**__________________

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

**I acknowledge receiving Ear, Nose and Throat Associates of Southeastern Connecticut's Privacy Notice.

SIGNATURE___________________________ **DATE**__________________