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

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

EARS, EYES, NOSE, THROAT

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

LUNGS

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

HEART

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

SKIN (skin, allergy, immune)

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

GASTROINTESTINAL

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

URINARY

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

MUSCULOSKELETAL

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

NEURO/PSYCH

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

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

Patient's Signature _____ **Date** _____

Name:_____

Date: _____ DOB:_____

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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**_____

Office and Financial Policies

Name: Date:

INSURANCE WAIVER:

You are asked to sign this waiver because of the ever changing rules and regulations of the insurance industry. In the past, our office has obtained prior authorizations and/or referrals for our patients from their primary care physicians for services performed in our office. We participate with many insurance companies and unfortunately there are many different plans under each insurance carrier and/or employer group plan. It is impossible for our office staff to stay abreast of all the rules and regulations set forth by each insurance carrier. Our staff spends long periods of time on hold waiting to speak to other offices and/or insurance carriers to obtain what is needed in order for office visits/testing to be covered. By signing below, you are indicating that you are aware and responsible to obtain any/all referrals or authorization required by your insurance carrier to be seen in a specialist office. Most insurance carriers will not back date an authorization for you. It is very important to know what kind of insurance you have and know all their requirements. This is an agreement between you and your insurance carrier. We are not a party to that agreement. We will submit your claim on your behalf to your insurance carrier. If authorization and/or referrals are not obtained prior to your appointment, and your insurance carrier denies your claim, you will be fully responsible for the charges.You are stating that you are aware of your insurance requirements and have obtained all necessary referrals and/or authorizations from your primary care physician. If you are not sure of your benefits, please feel free to contact your insurance carrier for clarification. You also understand and agree, to provide our office with any new coverage prior to services being rendered. Finally, you agree that we may request and use prescription medication history from other providers including digital downloads from pharmacies and/or third party pharmacy benefit payors. PLEASE INITIAL BELOW TO ACKNOWLEDGE YOUR UNDERSTANDING.

Initial: _____

OFFICE PROCEDURES POLICY

Please understand 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 INITIAL TO ACKNOWLEDGE YOUR UNDERSTANDING OF THIS POLICY SO THAT YOUR PHYSICIAN MAY PROCEED WITH A PROCEDURE IF IT IS INDICATED.

Initial: _____

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

Please initial below to acknowledge receiving Ear, Nose and Throat Associates of Southeastern Connecticut's Privacy Notice.

Initial: _____

SIGNATURE_____ **DATE**_____