ATLANTIC
Ear, Nose & Throat

PATIENT REGISTRATION

Please PRINT clearly and legibly in ink.

PATIENT INFORMATION

Please present your insurance card & photo ID

First Name: _____ Middle Name: _____ Last Name: _____

Social Security #: _____ - _____- _____ Date of Birth (M/D/Y): _____ / _____ / _____ Gender: ☐ Male ☐ Female

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Preferred Tel # to Use? ☐ Home ☐ Work ☐ Cell Email: _____

Race: ☐*American Indian/Alaska Native* ☐*Asian* ☐*Black /African American* ☐*Native Hawaiian/Pacific Islander* ☐*White* ☐*Prefer not to answer*

Ethnicity: ☐*Hispanic or Latino* ☐*Not Hispanic or Latino* ☐ *Prefer not to answer*

Marital Status: ☐*Child* ☐*Married* ☐*Single* ☐*Divorced* ☐*Widowed* Language*:* ☐*English* ☐*Spanish* ☐*Prefer not to answer*

Employment Status: ☐*Child* ☐*Student* ☐*Retired* ☐*Unemployed*

☐ *Employed*: Occupation: _____ Employer: _____

Preferred Pharmacy Name _____ City _____

Primary Care Doctor: _____ Address: _____ Tel:_____

Who recommended your visit? ☐ Primary Care Doctor ☐ Other Doctor: _____ Tel:_____
☐ ER ☐ Hospital Visit ☐ Other _____

How have you heard about us? ☐ Friend/Family: Name _____ ☐ Other (Specify): _____

Emergency Contact Name: _____ Telephone #: (_____) _____

PARENT OR LEGAL GUARDIAN if patient is a minor

Relationship to Patient: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Date of Birth (M/D/Y): _____ / _____ / _____ Gender: ☐ Male ☐ Female Social Security #: _____ - _____- _____

Employer: _____ Occupation: _____

I certify that the information provided on all patient registration and medical information forms is true and correct. You may contact me by mail at the address listed. You may contact me or leave a voice message at any of the telephone numbers I have provided.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ TODAY'S DATE:_____

Please fill out next pages →

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PATIENT INSURANCE

Please PRINT clearly and legibly in ink.

Patient Name _____ DOB _____

PATIENT INSURANCE

☐Self pay ☐Medicare (Secondary: _____ or ☐No secondary)

☐Private insurance _____ (Network: _____) ☐Personal insurance

☐Worker's Compensation ☐Auto/PIP ☐Other third party payor _____

INSURANCE POLICY HOLDER INFORMATION Relationship to Patient: _____

Primary Insurance Co: _____ Secondary Ins: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Date of Birth (M/D/Y): _____ / _____ / _____ Gender: ☐ Male ☐ Female Social Security #: _____ - _____- _____

Employer: _____ Occupation: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR):

☐ Same as patient ☐ Same as parent/guardian ☐ Other (see below) Relationship to Patient: _____

First Name: _____ Middle Initial: _____Last Name: _____

Date of Birth (M/D/Y): _____ / _____ / _____ Social Security #: _____ - _____- _____ Gender: ☐ Male ☐ Female

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Employer: _____ Occupation: _____

I certify that the information provided on all patient registration and medical information forms is true and correct. You may contact me by mail at the address listed. You may contact me or leave a voice message at any of the telephone numbers I have provided.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ TODAY'S DATE:_____

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PATIENT CONSENT

Please sign each section legibly in ink.

(If under 18 years old, must be signed by a parent or legal guardian.)

Patient Name: _____ DOB: _____

Consent to Treat, Release of Information, Assignment of Benefits and Financial Responsibility

I hereby give consent to all physicians and healthcare providers of Atlantic Ear, Nose & Throat, P.A. to provide treatment to the named patient. I understand that there is no guarantee or warranty, expressed or implied, as to any result or cure.

I hereby authorize Atlantic Ear, Nose & Throat, P.A. physicians and staff to obtain all necessary medical records from other doctor's offices, hospitals, clinics, surgery centers, test facilities and laboratories. I further authorize Atlantic Ear, Nose & Throat, P.A. to forward records of my evaluation and/or treatment to my referring and primary care physicians.

I also authorize Atlantic Ear, Nose & Throat, P.A. to release all information necessary to file my insurance / Medicare claim and to allow a photocopy of my signature to be used to process my current and any future insurance / Medicare claims. I hereby assign insurance / Medicare benefits to be paid directly to Atlantic Ear, Nose & Throat, P.A. I hereby give my consent to my information being used in the course of routine health care operations.

I understand that I am financially responsible for all charges incurred during the course of treatment, whether or not paid by any insurance, and any collection fees that I may incur. It is my responsibility to pay any deductible, co-insurance or co-payment amounts at the time of service. I also understand that I am responsible to obtain any authorizations or referrals necessary for services provided by Atlantic Ear, Nose & Throat, P.A.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **TODAY'S DATE:**_____

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payors, and conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and I may contact this organization at any time to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may discuss any portion of my medical record with anyone listed on the registration form and the following people:

(name) _____ (relationship) _____

(name) _____ (relationship) _____

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **TODAY'S DATE:**_____

OFFICE USE ONLY I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form but was unable to do so as documented below:

Date: Initials: Reason:

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MEDICAL INFORMATION: Please PRINT clearly in ink.

Patient Name:_____ **Date of Birth:** _____

Primary reason for today's visit: _____

Medication Allergies (*write "none" if none)*

_____

Other Allergies *(e.g. dyes, contrast, latex)*

_____

Current Medications *(write "none" if none) only list the names, not dose:*

_____

_____

Age:_____

Height:_____

Weight:____

Check all that apply:

Other Medical Conditions
❑ High Blood Pressure
❑ Bleeding Disorder
❑ Glaucoma
❑ Diabetes
❑ Stroke
❑ Thyroid Disease
❑ Sleep Apnea
❑ Asthma
❑ Cancer (of_____)
❑ Poor Circulation
❑ Heart Disease
❑ Other: _____

Check all that apply:

Past Surgeries
❑ Tonsillectomy
❑ Adenoidectomy
❑ Thyroidectomy
❑ Ear Surgery
❑ Sinus Surgery
❑ Nasal Septoplasty
❑ Carotid Artery Surgery
❑ Ear Tubes
❑ Pacemaker
❑ Heart Bypass / Valve
❑ Other: _____

Check all that apply:

Family History of Illness
❑ High Blood Pressure
❑ Bleeding Disorder
❑ Glaucoma
❑ Diabetes
❑ Stroke
❑ Thyroid Disease
❑ Hearing Loss
❑ Vertigo
❑ Cancer (of_____)
❑ Poor Circulation
❑ Heart Disease
❑ Other: _____

How often do you use Alcohol?
❑ Never
❑ Occasionally
❑ Daily: How Much ?

*Did you **ever** chew Tobacco?*
❑ Never did
❑ Yes
❑ Quit: When?

*Did you **ever** Smoke?*
❑ Never did
❑ Yes: ___ packs per day for ___ years
❑ Quit: When?

Review of Systems: Do you have any of these symptoms? Please check *yes* or *no* to each item…

		Yes	No
General	fever	❑	❑
	weight loss	❑	❑
	night sweats/chills	❑	❑
Ear, Nose & Throat	ear pain or itch	❑	❑
	dizziness	❑	❑
	nasal congestion	❑	❑
	ear drainage	❑	❑
	loss of smell	❑	❑
	throat pain	❑	❑
	hearing loss	❑	❑
	sinus pressure	❑	❑
	hoarseness	❑	❑
	ringing in ears	❑	❑
	nasal drainage	❑	❑
	snoring	❑	❑
Cardiac	chest pain when walking	❑	❑
	swollen ankles	❑	❑
	blackouts	❑	❑
Lung	cough	❑	❑
	shortness of breath	❑	❑
	blood in sputum	❑	❑
Endocrine	excessive sleepiness	❑	❑
	excessive thirst	❑	❑
	in ability to sleep	❑	❑
Heme/L	swollen glands	❑	❑
	bleeding problems	❑	❑
	blood transfusions	❑	❑
Allergy	sneezing	❑	❑
	post-nasal drip	❑	❑
	history of allergy shots	❑	❑
Eyes	dry eyes	❑	❑
	double vision	❑	❑
	excessive tears	❑	❑
Muscle	neck pain	❑	❑
	joint pains	❑	❑
	pain in jaw with chewing	❑	❑
Neuro	numbness	❑	❑
	paralysis/weakness	❑	❑
	headache	❑	❑
Psychiatric	depression	❑	❑
	anxiety	❑	❑
	memory loss	❑	❑
Skin	rash	❑	❑
	ulcers/growths	❑	❑
	discoloration	❑	❑
GI	heartburn	❑	❑
	difficulty swallowing	❑	❑
	nausea	❑	❑
GU	difficulty urinating	❑	❑
	blood in urine	❑	❑
	might you be pregnant now	❑	❑

Patient (or Guardian) Signature: _____ Date:_____