

Please PRINT clearly and legibly in ink.

PATIENT INFORMATION

Please present your insurance card & photo ID

1. First Name: _____ Middle Name: _____ Last Name: _____

2. Social Security #: _____ - _____ - _____ 3. Date of Birth (M/D/Y): ____ / ____ / ____ 4. Sex: M F

5. Home Address: _____ City: _____ State: _____ Zip Code: _____

6. Telephone #s: Home: (____) _____ Cell: (____) _____ Work: (____) _____

7. Preferred Tel # to Use? Home Cell Work 8. Email: _____

9. Mailing Address (if different from home address): _____

10. Emergency Contact Name: _____ Telephone #: (____) _____

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

12. Ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not to answer

13. Preferred Language: English Spanish Other _____ Prefer not to answer

14. Marital Status: Single Married Divorced Widowed

15. Employment Status: Child Student Retired Unemployed

Employed: Occupation: _____ Employer: _____

16. Pharmacy Name: _____ Address: _____ Tel: _____

17. Primary Care Doctor: _____ Address: _____ Tel: _____

18. Who recommended your visit? Primary Care Doctor Other Doctor Name: _____ Tel: _____

ER Hospital Visit Other (Specify: _____)

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

PARENT OR LEGAL GUARDIAN (e.g. if patient is a minor)

1. Relationship to Patient: _____

2. Last Name: _____ First Name: _____ Middle Initial: _____

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

4. Telephone #s: Home: (____) _____ Work: (____) _____ Cell: (____) _____

5. Date of Birth (M/D/Y): ____ / ____ / ____ 6. Gender: M F 7. Social Security #: _____ - _____ - _____

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 →

Patient Name _____

DOB _____

PATIENT INSURANCE

- Self pay / No Insurance
- Medicare: Regular Part B Part C Plan Name: _____
 Medicare Secondary Plan Name: _____ or No secondary)
- Insurance Plan (Name: _____) Network: _____
- Worker's Compensation Other third party payor _____

If your plan requires a referral, please ask your primary care doctor to send one to us for you.

Please bring your ID cards with you to your visit.

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: _____

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: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
	weight loss	<input type="checkbox"/>	<input type="checkbox"/>
	night sweats/chills	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
Ear, Nose & Throat	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>
	loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
	throat pain	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	
snoring	<input type="checkbox"/>	<input type="checkbox"/>	

		Yes	No
Cardiac	chest pain when walking	<input type="checkbox"/>	<input type="checkbox"/>
	swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
	blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Lung	cough	<input type="checkbox"/>	<input type="checkbox"/>
	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
	blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	excessive sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
	excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
	in ability to sleep	<input type="checkbox"/>	<input type="checkbox"/>
Heme/L	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
	blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	sneezing	<input type="checkbox"/>	<input type="checkbox"/>
	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
	history of allergy shots	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
	double vision	<input type="checkbox"/>	<input type="checkbox"/>
	excessive tears	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
Muscle	neck pain	<input type="checkbox"/>	<input type="checkbox"/>
	joint pains	<input type="checkbox"/>	<input type="checkbox"/>
	pain in jaw with chewing	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	numbness	<input type="checkbox"/>	<input type="checkbox"/>
	paralysis/weakness	<input type="checkbox"/>	<input type="checkbox"/>
	headache	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	depression	<input type="checkbox"/>	<input type="checkbox"/>
	anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Skin	rash	<input type="checkbox"/>	<input type="checkbox"/>
	ulcers/growths	<input type="checkbox"/>	<input type="checkbox"/>
	discoloration	<input type="checkbox"/>	<input type="checkbox"/>
GI	heartburn	<input type="checkbox"/>	<input type="checkbox"/>
	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	nausea	<input type="checkbox"/>	<input type="checkbox"/>
GU	difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
	might you be pregnant now	<input type="checkbox"/>	<input type="checkbox"/>

Patient (or Guardian) Signature: _____

Date: _____