PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name		**First**	**M.I**	**Race** □ White □ Black □ Native American □ Asian/Pacific Islander □ Other _____ □ Unknown/Refuse	**Ethnicity** □ Hispanic □ Non Hispanic **Language** □ English □ Spanish □ _____
Date of Birth	**Age**	**Social Security #**	**Gender**		
Home Phone #	**Cell Phone #**	**Work Phone #**			
Street Address	**City**	**State/Zip**		**Email**	
Employer	**Occupation**	**Employer Address**			

SPOUSE OR PARENT INFORMATION

Last Name	**First**	**Employer**
Date of Birth	**Social Security #**	**Employer Address**
Home Phone #	**Cell Phone #**	**Work Phone #**

EMERGENCY CONTACT INFORMATION

Contact Name	**Phone #**	**Relationship to patient**

INSURANCE INFORMATION

Is the reason for this office visit a work related injury? □ YES □ NO
If yes, please have paper work available to bill appropriate agency. Claim number _____
If work related incident is not stated at the time of visit, you may be personally responsible to pay in full for services rendered. If claim is denied for compensation, you will also be responsible for the outstanding balances on your account.

Please indicate primary insurance:

Insured's Name	**Insured's Social Security #**	**Policy ID**
Patient Relationship to Insured	**Insured's Date of Birth**	**Group #**
Occupation	**Insured's Employer**	
Work Phone #	**Insured's Employer Address**	

Please indicate secondary insurance:

Insured's Name	**Insured's Social Security #**	**Policy ID**
Patient Relationship to Insured	**Insured's Date of Birth**	**Group #**
Occupation	**Insured's Employer**	
Work Phone #	**Insured's Employer Address**	

HIPAA ~ NOTICE OF PRIVACY PRACTICES

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

ADDITIONAL FEES

In the event any lawsuit action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all cost, not limited to attorney's fees, court costs, collection fees, interest and any additional cost that this action may incur.

I certify that the information provided by me in applying for payment under the Title XVIII of the Social Security Act is correct

AUTHORIZATIONS

I agree and authorize EAR, NOSE AND THROAT OF YUMA, PLLC for any examination, treatment and procedures that may be performed during today's office visit. I understand that additional test may have been ordered and I understand that in order to obtain results a follow up appointment may be needed for my physician to discuss and review clinical findings.

I have read the Financial Policy, Information-Insurance form. I certify that this information is true to the best of my knowledge. I will notify EAR, NOSE AND THROAT OF YUMA, PLLC of any changes.

I authorize the release of any medical or other information necessary to process any claims for services rendered.
I authorize payment of medical benefits including Medigap benefits to the undersigned physician.

Signature	Date

PATIENT REGISTRATION

PATIENT NAME _____

TO ALL OF OUR NEW AND ESTABLISHED PATIENTS

PLEASE READ THIS PAGE CAREFULLY

Either you or your physician has scheduled you for an office visit today.

This is to notify you that depending on the reason for your visit today, additional procedures may be requested by the doctor and/or provider to evaluate your health needs. This cost is not included in the office visit. These procedures may include; but are not limited to:

Hearing tests
Cerumen (wax) removal
Foreign body removal
Incision and Drainage of abscess
Biopsy to be sent to pathology
Needle biopsy to be sent to pathology
Lesion removal to be sent to pathology
Ear tube placement
Nasal Cauterization
Flexible/Ridge Scope Nose/Throat
Not inclusive of all procedures

You or your insurance company will be billed for these procedures. You might be responsible for all or a portion of the billed charges depending on your deductible, copay, or co-insurance amount. Patients with no insurance will be responsible for visit and procedures at the time of service.

If an appointment is missed or less than 24 hours notice is given for cancellation, patient will be responsible for the following charges.

NO SHOW $50.00

PROCEDURES $65.00

These charges will not be covered by insurance.
After 2 NO SHOWS… patient will be dismissed from ENT of Yuma and will need to find another physician for their care.

Signature	Date

HEALTH HISTORY QUESTIONAIRE

PATIENT NAME _____**DATE** _____

What is the reason for your visit today? _____
Referring Physician: _____

MEDICAL HISTORY
Have you ever had any of the following?

☐ Heart Disease	☐ Sleep Apnea	☐ Stroke	☐ GI problems (heartburn)
☐ Diabetes	☐ High blood pressure	☐ HIV	☐ Arthritis (specify)
☐ Kidney Disease	☐ Hepatitis	☐ Other _____	
☐ Lung problems	☐ Cancer	_____	

Have you had any surgeries? ☐ Yes ☐ No
If yes, please describe
_____
_____
_____

Are you taking any medications? ☐ Yes ☐ No
If yes, please list below

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Name & Location:
_____

Do you have any allergies? ☐ Yes ☐ No
If yes, please describe
_____
_____
_____

FEMALE PATIENTS
Are you currently pregnant or is there a possibility you may be pregnant? ☐ Yes ☐ No

HEALTH HISTORY QUESTIONAIRE

PATIENT NAME _____ **DATE** _____

SOCIAL HISTORY

Yes ☐ No Tobacco Use _____ how many per day (packs) _____ chew
Yes ☐ No Did you smoke in the past? How long ago? _____
Yes ☐ No Alcohol _____ daily _____ weekly _____ socially
Yes ☐ No Marijuana/or other drug use _____

ENT REVIEW OF SYSTEMS

1) Please check the "YES" or "NO" box to indicate whether you presently have any of the following symptoms…
2) For any "YES" responses, please check "CURRENT" box if the system relates to the reason for your visit today.

		YES	NO	CURRENT
ALLERGY	*Seasonal allergies*	☐	☐	☐
EYES	*Double vision*	☐	☐	☐
NEUROLOGY	*Speech difficulties*	☐	☐	☐
GENERAL	*Bleeding disorders*	☐	☐	☐
CARDIAC	*Palpitations*	☐	☐	☐
HEMATOLOGY	*Prolonged bleeding*	☐	☐	☐
RESPIRATORY	*Wheezing/Shortness of breath*	☐	☐	☐
GASTRO INTESTINAL	*Heartburn*	☐	☐	☐
SKIN	*Unusual bruising*	☐	☐	☐
MUSCULOSKELETAL	*Arthralgias (joint pain)*	☐	☐	☐
PSYCHIATRIC	*Depression*	☐	☐	☐