

PATIENT REGISTRATION & HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION						
Patient's Last Name		First		M.I.	Race	Ethnicity
Date of Birth	Age	Social Security #		Gender	White Black Native American Asian/Pacific Islander Other Unknown/Refuse	Hispanic Non Hispanic Language English Spanish
Home Phone #	Cell Phone #		Work Phone #			
Mailing 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						
<p>Is the reason for this office visit a work related injury? YES NO</p> <p>If yes, please have paper work available to bill appropriate agency. Claim number _____</p> <p>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.</p>						
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		Please indicate primary insurance:		Policy ID		
Patient Relationship to Insured		Insured's Date of Birth		Group #		
Occupation			Insured's Employer			
Work Phone #			Insured's Employer Address			

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:

- 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
- 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.

Signature	Date
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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.

AUTHORIZATIONS	
<i>I certify that the information provided by me in applying for payment under the Title XVIII of the Social Security Act is correct</i>	I agree and authorize for any examination, David Hohuan, MD 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 David Hohuan, MD 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 & HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME _____ **DATE** _____

What is the reason for your visit today? _____

Referring Physician: _____

MEDICAL HISTORY Have you ever had any of the following?		FAMILY HISTORY Anyone in your family ever had any of the following?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer
<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease
<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease
<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Problems/Sleep Apnea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Problems/Sleep Apnea
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis
<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke
<input type="checkbox"/> YES <input type="checkbox"/> NO	GI Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	GI Problems
<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV
<input type="checkbox"/> YES <input type="checkbox"/> NO	Loss of Hearing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Loss of Hearing
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bleeding Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bleeding Problems
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other:

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

SOCIAL HISTORY

- Yes No Do you use Tobacco? 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	<i>Seasonal allergies</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<i>Double vision</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGY	<i>Speech difficulties</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENERAL	<i>Bleeding disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	<i>Palpitations</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGY	<i>Prolonged bleeding</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	<i>Wheezing/Shortness of breath</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTRO INTESTINAL	<i>Heartburn</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<i>Unusual bruising</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL	<i>Arthralgias (joint pain)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	<i>Depression</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FEMALE PATIENTS

Are you currently pregnant or is there a possibility you may be pregnant? | Yes | No

