Florence Ears, Nose & Throat, PC

Patient Registration/Authorization/Consent Form

Please Present Insurance Card(s) and Photo I.D. for Copying

Patient Information

First Name_____ M.I._____ Last Name_____

SS#_____ D.O.B_____ Sex __M__F Marital Status __S __M__D__W__Sep

Address_____ City_____ STATE/ZIP_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____

Employer_____

Primary Care Physician_____

Referring Physician_____

Pharmacy Name and Location_____

Emergency Contact_____ Relation_____ Phone_____

___ Check here to decline answering the following 3 questions

1 My preferred language is:

- **A. English**
- **B. Spanish**
- **C. Other_____**

2 My race is:

- **A. American Indian**
- **B. Asian**
- **C. Black/African/American**
- **D. Hawaiian/Pacific Islander**
- **E. White/Caucasian**
- **F. Other_____**

3. My Ethnicity is:

- **A. Hispanic or Latino**
- **B. Not Hispanic or Latino**

Insurance Information

Primary Insurance_____

Policy Holder Name_____ID#_____

Policy Holder DOB_____ SS#_____

Policy Holder Employer_____

Secondary Insurance_____

Policy Holder Name_____ID#_____

Policy Holder DOB_____ SS#_____

Policy Holder Employer_____

Were you injured at work or is your complaint related to an accident? ___yes ___no

Name and relationship, other than emergency contact, allowed to discuss your health information:

_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize any medical information necessary to process an insurance claim.

Patient /Guardian Signature_____ Date_____

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Health History Questionnaire

The following information is very important to your health. Please fill out correctly.

Name_____ D.O.B._____ Age_____ Sex ___M ___F

Home Phone_____ Cell Phone_____ Work Phone_____

Weight_____ Height_____

Chief Complaint_____

Past Medical History:	**High Blood Pressure**	**___ Self ___Mother ___Father**
Please check all that apply to	**Diabetes**	**___ Self ___Mother ___Father**
Self or family	**Asthma**	**___ Self ___Mother ___Father**
	Heart Disease	**___ Self ___Mother ___Father**
	Heart Attack	**___ Self ___Mother ___Father**

Other: _____

Past Surgical History: _____

_____

Medications:_____

_____

Allergies:_____

Social History:

Marital Status: __ S __ M __ W __ D __ SEP Occupation_____

Children? ____ Yes ____ No If yes, how many _____

Do you smoke? _____ Yes _____ No If yes, how much _____

Previously smoke? ____ Yes ____ No If yes, how much _____

Do you drink alcohol? ____ Yes ____ No If yes, how much _____

Previously drink? _____ Yes ____ No If yes, how much _____

Patient Review of Systems

Patient Name:_____ **Date:**_____

Constitutional Symptoms:	Yes	No	Genitourinary :	Yes	No
Fever	( )	( )	Blood in urine	( )	( )
Weight Loss	( )	( )	Pain with urination	( )	( )
Night Sweats	( )	( )	Involuntary loss of urine	( )	( )
Chills	( )	( )			
Eyes :	**Yes**	**No**	**Gastrointestinal:**	**Yes**	**No**
Recent visual loss	( )	( )	Abdominal pain	( )	( )
Double vision	( )	( )	Vomiting	( )	( )
Blind spots	( )	( )	Dark or bloody stools	( )	( )
Tunnel vision	( )	( )	Diarrhea	( )	( )
Trauma	( )	( )	Involuntary loss of stools	( )	( )
Ears, Nose, Mouth, Throat:	**Yes**	**No**	**Musculoskeletal:**	**Yes**	**No**
Recent hearing loss	( )	( )	Joint pain	( )	( )
Ear pain	( )	( )	Joint swelling	( )	( )
Nose bleeds	( )	( )	Inflammation	( )	( )
Sore throat					
Cardiac/Circulatory:	**Yes**	**No**	**Endocrine:**	**Yes**	**No**
Chest pain	( )	( )	Breast discharge	( )	( )
Swelling of feet/ankles	( )	( )	Irregular/absent menstrual cycle	( )	( )
Pain in lower legs	( )	( )	Heat/cold intolerance	( )	( )
When walking	( )	( )	Recent severe weight gain	( )	( )
Abnormal heart rhythm	( )	( )	Possible pregnancy	( )	( )
Hematologic:	**Yes**	**No**	**Respiratory:**	**Yes**	**No**
Bleeding problems	( )	( )	Shortness of breath	( )	( )
Frequent/recurrent infections	( )	( )	Cough	( )	( )
Previous bleeding problems with surgery	( )	( )	Cough with bleeding	( )	( )

_____

_____ _____

Patient Signature/Date **Physician Signature / Date**

The information provided on my health history questionnaire form is true and correct to the best of my knowledge.

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Patient Record Of Disclosures

In general the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone
( ) OK to leave message with detailed information
( ) Leave message with call back number only

____ Written Communication
( ) OK to mail to my home address
( ) OK to mail to my work/office address
( ) OK to fax to this number _____

____ Work Telephone
( ) OK to leave message with detailed information
( ) Leave message with call back number only

____ Emergency Contact
( ) Leave message with emergency contact
( ) Leave message with call back only

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

My protected health information may be shared with:
(check all that apply)

_____ Spouse
_____ Mother
_____ Father
_____ Grandmother
_____ Grandfather
_____ Other (please specify)_____

_____

_____ _____
Patient Signature **Date**

_____
Print Patient Name