

Date: _____

Patient Registration Form

PATIENT INFORMATION:

Name: _____ Male: _____ Female: _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Date of Birth: _____
Work Phone: _____ Social Security #: _____
Employer Name: _____ Marital Status: S M W

ADDITIONAL INFORMATION:

How Were you Referred to this Practice? _____
Who is Your Primary Care Physician (PCP): _____
PCP Phone & Location: _____
Emergency Contact Name & Phone: _____
Friends or Family Seen by our Physicians: _____

RESPONSIBLE PARTY/PRIMARY INSURANCE INFORMATION: (from insurance card)

Company: _____
Telephone: _____ Policy Holder's Name: _____
Policy Holder's ID: _____ Group ID: _____
Policy Holder's DOB: _____ Policy Holder's SSN: _____
Coplay: _____ Effective Dates: _____
Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION: (from insurance card)

Company: _____
Telephone: _____ Policy Holder's Name: _____
Policy Holder's ID: _____ Group ID: _____
Policy Holder's DOB: _____ Policy Holder's SSN: _____
Coplay: _____ Effective Dates: _____
Relationship to Patient: _____

THIRD INSURANCE INFORMATION: (from insurance card)

Company: _____
Telephone: _____ Policy Holder's Name: _____
Policy Holder's ID: _____ Group ID: _____
Policy Holder's DOB: _____ Policy Holder's SSN: _____
Coplay: _____ Effective Dates: _____
Relationship to Patient: _____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS:

I understand that I am financially responsible and agree to pay all of Adult & Pediatric Ear, Nose & Throat's charges and any related charges that are not paid by insurance or any other third party payor. I authorize payment directly to Adult & Pediatric Ear, Nose & Throat, P.C., DBA Colorado ENT Specialists for all benefits otherwise payable to me. I understand that if I do not provide all of the requested or necessary information, I will be billed directly for all charges until such information is provided.

Because of concerns that there may be a conflict of interest when a physician refers a patient to a healthcare facility in which the physician has a financial interest, federal law prohibits me, with certain exceptions, from referring you for clinical procedures, laboratory service, pharmacy services, radiation therapy services, or x-ray or imaging services to a facility in which I or any of my immediate family members have financial interest.

Because the type of financial interest I have in the providers listed below, the law prohibits me referring you to these providers on the condition that I disclose financial interest. This disclosure is intended to help you make an informed decision about your health care.

I have financial relationship with the following providers:

HealthSouth Surgery Center of Aurora
Crown Point Surgery Center

Your care provided by this provider will be billed to your insurance by the provider directly.

CONSENTS AND DISCLOSURES:

I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instructions of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the result of my treatment at Colorado ENT Specialists, P.C. I understand that Colorado ENT Specialists, P.C. encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care. NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT, AND ACCEPT ITS TERMS.

Signature of Patient/Responsible Person **X** _____ Date _____

Relationship (if other than Patient) _____

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Who sent you to see us? _____ Who is your primary care physician? _____

Describe your major symptoms or reason for your visit today: _____

Is this illness/injury auto or work related? _____ How long have your symptoms been present? _____

What makes the symptoms better or worse? _____

What treatments have been tried so far? _____

What tests have been performed (e.g. labs, x-rays)? _____ Have you had allergy testing? _____

Have you had any of the following health problems? Check all that apply.

- Heart Attack Tuberculosis (TB) Back Problems Kidney Infections Arthritis/Joint Pain
- Heart Disease Pneumonia Diabetes AIDS/HIV+ Cystic Fibrosis
- Heart Murmur Stroke Hypoglycemia Thyroid Problems Down's Syndrome
- Chest Pain Seizures Hepatitis Sinus Disease Cancer, Type: _____
- High Blood Pressure Head Injury Jaundice Hearing Loss None Of The Above
- Asthma Migraines Bleeding Disorder Reflux Disease Other: _____
- Emphysema Meningitis Anemia Ulcers _____

List all the medications you are currently taking:

Medication:	Dose:	Medication:	Dose:	Medication:	Dose:

Allergies to Medications: _____

Preferred Pharmacy: _____ Location/Phone: _____

Have you ever smoked? (circle) yes no Do you smoke now? yes no if yes, _____ packs per day for the last _____ years

Alcohol use? _____ drinks per day week month Recreational drug use? (circle) yes no Type(s): _____

Who lives with you at home? _____ What is your occupation? _____

Please list any surgeries you have had including dates:

Have any of your family members had the following health problems? Check all that apply

- Heart Disease Stroke Hepatitis Thyroid Problems None Of Those Listed
- High Blood Pressure Migraines Bleeding Disorder Hearing Loss Malignant Hyperthermia
- Tuberculosis (TB) Arthritis/Joint Pain Reflux Disease AIDS/HIV+ Other Not Listed:
- Asthma Diabetes Ulcers Cancer, Type: _____

Please check all symptoms that apply to you:

- | | | | | |
|---|--|---|--|---|
| <p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Change in vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Excess tearing <p>Ears</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing of ears <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear drainage <input type="checkbox"/> Ear fullness <input type="checkbox"/> Dizziness | <p>Nose</p> <ul style="list-style-type: none"> <input type="checkbox"/> Obstruction/congestion <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Drainage/pus <input type="checkbox"/> Loss of smell <p>Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recent voice change <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Can't clear throat <input type="checkbox"/> Chronic cough <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat <input type="checkbox"/> Loss of taste <p>Pulmonary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Pain with breathing | <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Swollen legs/ankles <input type="checkbox"/> Dizziness or fainting <input type="checkbox"/> Palpitations <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Diarrhea <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine | <p>Neurologic/Psych</p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Tingling <input type="checkbox"/> Convulsions <input type="checkbox"/> Blackouts <input type="checkbox"/> Sensory disturbances <input type="checkbox"/> Motor disturbances <input type="checkbox"/> Depression <input type="checkbox"/> Memory difficulties <p>Hematology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Prior transfusion <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Increased water intake | <p>Skin/musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin lesions/rashes <input type="checkbox"/> Pigmentation changes <input type="checkbox"/> Joint pain/limited motion <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Back pain <p>Allergy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inhalant allergy <input type="checkbox"/> Contact allergy <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Food allergy <input type="checkbox"/> Latex allergy |
|---|--|---|--|---|



Missed Appointment Policy

Our office will contact each patient within the first business day prior to their scheduled appointment to remind the patient of his/her appointment with our physician. If you are unable to keep the appointment, please contact our office prior to your appointment to reschedule or cancel.

If you miss your appointment and/or fail to call prior to your scheduled appointment a \$50 charge may be billed to you, not your insurance carrier.

Once you have missed three appointments, without notifying our office, our office has the option to refuse future care and/or treatment.

I have read and understand the above policy.

Signature of Patient or Legal Guardian

Date



Contact Permission

Your physician, or office staff, may need to contact you at times. By filling out the information below, we will be better able to serve you.

PATIENT NAME: _____

In an effort to protect your privacy, we have developed a policy in reference to leaving messages containing medical information.

- ◆ We will NOT leave messages with anyone except the patient or legal guardian.
- ◆ We will NOT leave any information on an answering machine or voice mail.

UNLESS...

We have your written permission.

Please read below and carefully consider whom you want to have access to your medical information.

I, _____ give Colorado ENT Specialists my permission to leave phone messages regarding my medical care and/or billing (including appointment reminders) at the following phone numbers....

Home Answering Machine: # _____

Office Answering Machine: # _____

With My Spouse: # _____

Other: # _____

Signature:

Date: