WEST RIVER
EAR, NOSE & THROAT

Prof., LLC

PATIENT REGISTRATION FORM

Patient Information

Last Name: First Name: M.I.:			Preferred name/nickname:
Mailing Address:		Sex: ☐ Male ☐ Female ☐ Decline	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone w/ext.	
Preferred method of communication: ☐Voice ☐ Text ☐ Email ☐Other:		Preferred Phone: ☐ Cell ☐ Home ☐Work ☐Other:	
Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner		Employer:	
Date of Birth:	Soc. Sec. #:	Email address:	
Emergency Contact:	Phone:	Relationship to Patient:	

Responsible Party

Person responsible for the bill **(Only if patient is a minor child):** Last Name: First Name: M.I.:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Phone:
Address:	City/State/Zip:	
Employer:		

You may attach a copy of your insurance card instead of completing the below information

Insurance & Payment Info

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Insurance ID #:	Insurance ID #:
Group #:	Group #:
Policy Holders Name:	Policy Holders Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Relationship to Patient:	Relationship to Patient:
Employer Name	Employer Name

Other Information

Can we leave messages regarding your medical care, test results and financial obligations or business office needs?: ☐ No ☐ Yes. If yes, what is your preferred contact method: ☐ Cell ☐ Home ☐ Work
Race (please select one): ☐ Caucasian or White ☐ Native American or Alaska Native ☐ Asian ☐ Black of African-American ☐ Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Other Race ☐ Decline
Ethnicity (please select one): ☐ Hispanic ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other:
Preferred Pharmacy Name & Location:
Family or Primary Care Provider(s):

I certify that the information I have furnished is complete and accurate. I hereby authorized payment of benefits payable under my insurance plan and/or of any government payment plan be paid directly to West River Ear Nose and Throat, Prof., LLC (WRENT), which I agree will be credited to my account. I authorize assignee to obtain my plan provisions under ERISA and to act as authorized representative on my behalf on insurance claims. A photocopy of this assignment is to be considered as valid as the original. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I understand that I will be responsible to WRENT for all amounts including those not paid by my insurance payer due to their payment rules or guidelines. A finance charge of 18% will be charged on all guarantor owed balances after 60 days. I hereby give my consent for WRENT to use and disclose my protected health information for the purposes of treatment, payment and health-care operations.

Signed: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices outlines our obligations to you under federal privacy law. We are obligated to provide you with a copy of our Notice at the time of your appointment. **In addition, we ask you to let us know to whom you will allow access to your medical records, account and/or billing information.** The phone number(s) and address you provide us will be used to contact you for appointment reminders, medical follow-up, questions regarding account information, billing and insurance claims questions, mailing account statements and other contacts unless you tell us otherwise. We may ask you to complete an authorization for release of medical information if there are any questions or concerns.

I acknowledge that I have received a copy of West River Ear Nose and Throat, Prof., LLC's Notice of Privacy Practices. If you would like a copy of our Privacy Practices, please ask the front desk.

Patient/Responsible Party Signature_____ **Date** _____

❑ Attempt made to obtain acknowledgement of receipt of Notice of Privacy Practices however the patient either refused to sign or other:
_____

Please list the name(s) of family, friends or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing and insurance questions, etc.:

Name	Relationship	E-mail address	Phone #
Name	Relationship	E-mail address	Phone #
Name	Relationship	E-mail address	Phone #
Name	Relationship	E-mail address	Phone #

CONSENT FOR CARE OF MINOR

Children under the age of 14 must be accompanied by an adult for any appointment.

As the Parent or guardian to _____, Age _____, a minor, I authorize the following:

____ I authorize _____, to be seen and treated at West River Ear, Nose, and Throat without a parent or guardian.
Initials

____ I authorize _____, to be seen and treated at West River Ear, Nose, and Throat when accompanied only by the
initials following adult, friend, child care provider or other:

Name	Relationship
Name	Relationship
Name	Relationship

This consent shall remain in full force and effect until revoked by me or the minor attains eighteen (18) years of age.

Parent or Guardian	Date

WEST RIVER
EAR, NOSE & THROAT
PROF., LLC

Date:_____

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age:_____

Referring Provider: _____ Height: _____ Weight: _____

How did you hear about us: _____

CHIEF COMPLAINT:

What medical problems would you like us to assist you with today?

_____

_____

ALLERGIES:

Please list any drug allergies and corresponding reactions:

_____

_____

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken

Medication	Dosage	How often taken

PAST SURGICAL HISTORY

Procedure	Date	Surgeon

FAMILY HISTORY (immediate family only)

Does anyone in your family have a history of any of the following?

	Yes (if yes-then who)	No		yes (if yes-then who)	No
Heart Disease		☐	Kidney Disease		☐
High Blood Pressure		☐	Diabetes		☐
Lung Disease		☐	Bleeding Disorders		☐
Cancer		☐	Other:		☐

SOCIAL HISTORY

	Yes	No	
Have you ever smoked?	☐	☐	If so, when did you quit?
Do you currently smoke?	☐	☐	If so, how much?
Are you exposed to passive smoke?	☐	☐	If so, how much?
Do you drink alcohol?	☐	☐	If so, how much?
Any illicit drug use?	☐	☐	If so, please list these drugs.

Personal History (Patient):

Cardiovascular:
Coronary Artery Disease ☐ **Yes**
Elevated cholesterol (hyperlipidemia) ☐ **Yes**
High Blood Pressure (hypertension) ☐ **Yes**

Gastrointestinal:
Hepatitis ☐ **Yes**
Hernia ☐ **Yes**
Gastroesophageal Reflux ☐ **Yes**

Genitourinary:
Prostate enlargement (Prostatitis) ☐ **Yes**
Kidney Stones (Nephrolithiasis) ☐ **Yes**
Acute Renal Failure ☐ **Yes**

Ear / Nose / Throat: (HEENT)
Cataracts ☐ **Yes**
Glaucoma ☐ **Yes**
Chronic ear infections (otitis media) ☐ **Yes**
Hearing loss ☐ **Yes**
Sinus problems (chronic sinusitis) ☐ **Yes**
Nasal polyps ☐ **Yes**
Nasal Allergies ☐ **Yes**
Recurrent tonsillitis ☐ **Yes**
Tinnitus ☐ **Yes**
Vertigo ☐ **Yes**

Hematologic:
Anemia ☐ **Yes**

Immunologic:
Allergies Type:_____ ☐ **Yes**
Food allergies Type:_____ ☐ **Yes**
HIV / AIDS ☐ **Yes**

Infectious Disease:
Mononucleosis ☐ **Yes**
STD Type:_____ ☐ **Yes**

Metabolic/endocrine:
Diabetes Type:_____ ☐ **Yes**
Thyroid deficiency (hypothyroidism) ☐ **Yes**
Thyroid excess (hyperthyroidism) ☐ **Yes**

Neoplastic:
Cancer Type:_____ ☐ **Yes**

Neurologic:
Migraine ☐ **Yes**

Obstetric:
Are you currently pregnant? ☐ **Yes**
Pregnancy Date(s):_____

Psychiatric:
Adjustment Disorder – Anxiety ☐ **Yes**
Major Depression ☐ **Yes**

Pulmonary:
Asthma ☐ **Yes**
COPD/Emphysema ☐ **Yes**
Sleep Apnea ☐ **Yes**
Tuberculosis ☐ **Yes**

Miscellaneous:
Weight Change ☐ **Yes**
Anesthesia Reaction ☐ **Yes**
Miscellaneous PEDIATRIC ☐ **Yes**
Complications during Pregnancy ☐ **Yes**
Complications during Delivery ☐ **Yes**
NICU stay >48hrs: ☐ **Yes**
Preterm birth ☐ **Yes**

SIGNATURE: _____ **DATE:** _____

THANK YOU

Reviewed by:_____