EAR, NOSE, AND THROAT FAMILY CLINIC OF WISCONSIN, S.C

Patient Registration Form

Patient Information

Patient's First Name		Middle Name	Last Name		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address			City	State	Zip
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Pharmacy		
Pharmacy Address	Emergency Contact Name		Emergency Contact Phone/ Relation to Patient		

Patient Employer/School Information

Employer/School	Occupation	Employer Phone

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan Number	
Group Number		Insured's Name (as it appears on insurance card or ID)	
Insured's Number		Relation to Patient	Insured's Social Security Number
Insured's Birthdate	→	HOW DID YOU HEAR ABOUT US? PREFERABLY THE FIRST TIME	

Secondary Health Insurance (Please Note: If you do not have a secondary insurance, we ask you to write the word NONE in the box)

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient
(I WISH TO BE CONTACTED IN THE FOLLOWING MANNER) CIRCLE ONE **WORK PHONE HOME PHONE WRITTEN ALL OF THE OPTIONS LISTED**	MAY WE LEAVE A MESSAGE?	**ADDITIONAL CONTACTS WE MAY SHARE WITH**

DISCLAIMER

We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowledge of your insurance benefits is your own responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains. If your account is more than 90 days past due, it will automatically forward to our collection agencies system. Partial payments will not be accepted unless otherwise negotiated. By signing this statement, I agree to assume responsibility for services not paid by my Health Insurance, in whole or part. I further authorize the release of any medical information necessary to process my claims.

Signature of Patient or Authorized Guardian ____________________ Date ____________

Date of Appointment: ___________________________

______________________ ________ ________
Name Gender Age

Medical History Questionnaire- **Check all that apply**

CHEST PAIN __
DIFFICULTY BREATHING __
HEART ISSUES __
LUNG ISSUES __
KIDNEY ISSUES __
POSITIVE HIV/ AIDS __
NASAL ALLERGY __
SINUS INFECTIONS __

HIGH BLOOD PRESSURE __
HEPATITIS __
ULCER __
ANEMIA __
ASTHMA __
DIABETES __
POST NASAL DRIP __
NOSE BLEEDS __

STUFFY NOSE __
HEADACHES __
DIZZINESS __
HEARING LOSS __
STROKES __
TIA'S __
HEART MUR MUR __
SNORING/ SLEEP APNEA __

Please Circle Yes or No

Recent Cold/ Flu	Yes – No	Liver/ Kidney Disease	Yes – No
Chest Pain/ Angina	Yes – No	Acid Reflux/ GERD	Yes – No
Heart Attack/ Irregular heart beat	Yes – No	Stroke/ TIA/ Seizures	Yes – No
Angioplasty/ Stent	Yes – No	Paralysis/ Muscle Disease	Yes – No
High Blood Pressure	Yes – No	Bleeding Problems/ Easy bruising	Yes – No
Asthma/ COPD/ Shortness of Breath	Yes – No	Diabetes/ Thyroid Disease	Yes – No
Sleep Apnea/ CPAP/ Sever Snoring	Yes – No	Smoking	Yes – No
Alcohol Use	Yes – No	Recreational Drugs	Yes – No
Substance Dependence	Yes – No	Unusual reaction to Anesthesia	Yes – No
Possibility of pregnancy	Yes – No	Exposure to HIV/ AIDS	Yes – No

Please list all operations and hospitalizations you have ever had, along with approximate dates:

____

Any major illness not listed above

____

Who is your Primary Care Physician? ______________________ May we contact them? Yes/ No

Current Medications

Allergies to Medications

I agree that the above information is complete and correct.

Patient:____ Date:_______________

Name Gender Age

Date of Appointment: ______________________

EAR, NOSE, AND THROAT FAMILY CLINIC OF WISCONSIN, S.C

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. •
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Signature: ____Date: __________