

Patient Registration – Stachler ENT
www.stachlerent.com

Please Furnish Insurance Cards and a Picture ID / Driver's License

Patient Name _____ Age _____ Birth Date _____

Primary Care Physician: _____ City: _____ Zip Code: _____ Office Phone: _____

Please Circle: Male / Female Social Security#: _____ Marital Status: S M D W Other

Patient's Home Address: _____ City _____ State _____ Zip Code: _____

Patient's Home Phone: _____ Cell Phone: _____

Patient Email Address: _____ FaceBook: _____

Patient's Employer: _____ Work Phone: _____

Work Address: _____ If self-employed, name of business: _____

Spouse Name: _____ Birthdate: _____ Social Security#: _____

Spouse Employer: _____ Work Phone: _____

If patient is under parent/guardian's insurance:

Patient/Guardian Name _____ Birthdate: _____ Social Security#: _____

Address: _____ City: _____ State: _____

Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Other Parent/Guardian Name: _____ Birthdate: _____ Social Security#: _____

Employer: _____ Work Phone: _____

Insurance Information

Name of Primary Insurance: _____ Contract# _____

Subscriber's Name: _____ Patient Relation to Subscriber: _____

Secondary Insurance (Supplemental Policy): _____ Contract# _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

I / We authorize the physician to:

- 1.) Leave a message on my/our home phone. Yes No
- 2.) Speak to a family representative Yes No

regarding test results and subsequent recommendations. Exceptions are: _____

Under our professional and ethical obligations we are required to maintain physician-patient confidentiality and your privacy. Privacy policies of the Gramm-Leach-Bliley Act insure our professional and ethical obligations to you. Any release of information requires a separate written and signed authorization from the patient or legal guardian. _____ (Initial)

Signing of this document provides only consent for treatment at this time and forward until revoked in writing by the patient or legal representative.

(Sign & Date)

I hereby authorize payment directly to the physician for the medical and/or surgical services. I understand that if the physicians of this office are not providers of my insurance, or if I am not covered by insurance, then payment for services are my full responsibility. I agree to pay bank, credit bureau and office billing expenses for any delinquent accounts. I authorize the physicians of this office to release any information in the course of treatment to only the insurance company. I have read and fully understand this insurance assignment and agreement.

Patient Signature /or Legal Guardian if patient is a minor

Date

Please Circle: Mr. Mrs. Miss Ms Patient Name: _____ Date of Birth _____

Referred By: _____ Primary Care Physician _____

Review of Systems

Yes	No	<u>Cardiovascular</u>	Yes	No	<u>Hepatic (Liver)</u>	Yes	No	<u>Hematologic (Blood)</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell
<input type="checkbox"/>	<input type="checkbox"/>	Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure				<input type="checkbox"/>	<input type="checkbox"/>	Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse			<u>Endocrine</u>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease			<u>Pediatric (if applies)</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Abnormalities at birth
<input type="checkbox"/>	<input type="checkbox"/>	Other				<input type="checkbox"/>	<input type="checkbox"/>	Premature
		<u>Respiratory</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Neurologic</u>	<input type="checkbox"/>	<input type="checkbox"/>	Birth weight _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	How early _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea (Breath holding)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease			Other	<input type="checkbox"/>	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<u>Gastro-Intestinal</u>			<u>Allergy</u>
<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Previous Allergy Testing
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Previous Allergy Shots
		<u>Renal (Kidney)</u>	<input type="checkbox"/>	<input type="checkbox"/>	GI Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Environmental (dust, mold)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure			Other	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal (trees, grass, pollens)
<input type="checkbox"/>	<input type="checkbox"/>	Other				<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies

Past Medical and Social History

Please list all medications currently taking	Preferred Pharmacy
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medication allergies and the reactions you've had to them: _____

Past Surgical History: _____

Are you currently pregnant? _____ Are you HIV positive or at risk? _____

Do you use alcohol? _____ How often? _____ Do you sleep well? _____

Do you smoke? _____ How often? _____ Have you had cancer? _____

Reason for visit: _____

Patient Signature / Legal Guardian if patient is a minor _____ Date _____