ATLANTIC
Ear, Nose & Throat

PATIENT REGISTRATION

Please PRINT clearly and legibly in ink.

PATIENT INFORMATION

Please present your insurance card & photo ID

1. First Name: _____ Middle Name: _____ Last Name: _____

2. Social Security #: _____ - _____- _____ **3.** Date of Birth (M/D/Y): _____ / _____ / _____ **4.** Sex: ☐ M ☐ F

5. Home Address:_____City: _____ State: _____ Zip Code: _____

6. Telephone #s: Home: (_____) _____ Cell: (_____) _____Work: (_____) _____

7. Preferred Tel # to Use? ☐ Home ☐ Cell ☐ Work **8.** Email: _____

9. Mailing Address (if different from home address):_____

10. Emergency Contact Name: _____ Telephone #: (_____) _____

11. Race: ☐ *American Indian/Alaska Native* ☐ *Asian* ☐ *Black /African American*
☐ *Native Hawaiian/Pacific Islander* ☐ *White* ☐ *Prefer not to answer*

12. Ethnicity: ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐ *Prefer not to answer*

13. Preferred Language*:* ☐ *English* ☐ *Spanish* ☐ *Other* _____ ☐ *Prefer not to answer*

14. Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

15. Employment Status: ☐ *Child* ☐ *Student* ☐ *Retired* ☐ *Unemployed*
☐ *Employed:* Occupation: _____ Employer: _____

16. Pharmacy Name: _____ Address: _____ Tel: _____

17. Primary Care Doctor: _____ Address: _____ Tel:_____

18. Who recommended your visit? ☐ Primary Care Doctor ☐ Other Doctor Name: _____ Tel: _____
☐ ER ☐ Hospital Visit ☐ Other (Specify: _____)

19. How have you heard about us? ☐ Friend/Family: Name _____ ☐ Other (Specify): _____

PARENT OR LEGAL GUARDIAN (e.g. if patient is a minor)

1. Relationship to Patient: _____

2. Last Name: _____ First Name: _____ Middle Initial: _____

3. Street Address: _____City: _____ State: _____ Zip Code: _____

4. Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

5. Date of Birth (M/D/Y): _____ / _____ / _____ **6.** Gender: ☐ M ☐ F **7.** Social Security #: _____ - _____- _____

I certify that the information provided on all patient registration and medical information forms is true and correct. You may contact me by mail at the address listed. You may contact me or leave a voice message at any of the telephone numbers I have provided.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ TODAY'S DATE:_____

Please fill out next pages →

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PATIENT INSURANCE

Please PRINT clearly and legibly in ink.

Patient Name _____ DOB _____

PATIENT INSURANCE

☐ Self pay / No Insurance
☐ Medicare: ☐ Regular Part B ☐ Part C Plan Name: _____
☐ Medicare Secondary Plan Name: _____ or ☐ No secondary)
☐ Insurance Plan (Name: _____) ☐ Network: _____
☐ Worker's Compensation ☐ Other third party payor _____

If your plan requires a referral, please ask your primary care doctor to send one to us for you.

Please bring your ID cards with you to your visit.

INSURANCE POLICY HOLDER INFORMATION Relationship to Patient: _____

Primary Insurance Co: _____ Secondary Ins: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Date of Birth (M/D/Y): _____ / _____ / _____ Gender: ☐ Male ☐ Female Social Security #: _____ - _____- _____

Employer: _____ Occupation: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR):

☐ Same as patient ☐ Same as parent/guardian ☐ Other (see below) Relationship to Patient: _____

First Name: _____ Middle Initial: _____Last Name: _____

Date of Birth (M/D/Y): _____ / _____ / _____ Social Security #: _____ - _____- _____ Gender: ☐ Male ☐ Female

Street Address:_____ City: _____ State: _____ Zip Code: _____

Telephone #s: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Employer: _____ Occupation: _____

I certify that the information provided on all patient registration and medical information forms is true and correct. You may contact me by mail at the address listed. You may contact me or leave a voice message at any of the telephone numbers I have provided.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ TODAY'S DATE:_____

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PATIENT CONSENT

Please sign each section legibly in ink.

(If under 18 years old, must be signed by a parent or legal guardian.)

Patient Name: _____ DOB: _____

Consent to Treat, Release of Information, Assignment of Benefits and Financial Responsibility

I hereby give consent to all physicians and healthcare providers of Atlantic Ear, Nose & Throat, P.A. to provide treatment to the named patient. I understand that there is no guarantee or warranty, expressed or implied, as to any result or cure.

I hereby authorize Atlantic Ear, Nose & Throat, P.A. physicians and staff to obtain all necessary medical records from other doctor's offices, hospitals, clinics, surgery centers, test facilities and laboratories. I further authorize Atlantic Ear, Nose & Throat, P.A. to forward records of my evaluation and/or treatment to my referring and primary care physicians.

I also authorize Atlantic Ear, Nose & Throat, P.A. to release all information necessary to file my insurance / Medicare claim and to allow a photocopy of my signature to be used to process my current and any future insurance / Medicare claims. I hereby assign insurance / Medicare benefits to be paid directly to Atlantic Ear, Nose & Throat, P.A. I hereby give my consent to my information being used in the course of routine health care operations.

I understand that I am financially responsible for all charges incurred during the course of treatment, whether or not paid by any insurance, and any collection fees that I may incur. It is my responsibility to pay any deductible, co-insurance or co-payment amounts at the time of service. I also understand that I am responsible to obtain any authorizations or referrals necessary for services provided by Atlantic Ear, Nose & Throat, P.A.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **TODAY'S DATE:**_____

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 payors, and 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 its Notice from time to time and I may contact this organization at any time to obtain a current copy of the Notice. 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.

You may discuss any portion of my medical record with anyone listed on the registration form and the following people:

(name) _____ (relationship) _____

(name) _____ (relationship) _____

OR ☐ None

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **TODAY'S DATE:**_____

OFFICE USE ONLY I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form but was unable to do so as documented below:

Date: Initials: Reason:

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PATIENT MEDICAL HISTORY

Please PRINT clearly in ink.

Patient Name _____ Date of Birth _____

Primary reason for today's visit _____

Allergies *(write "none" if none)*	Current Medications *(list only names & "none" if none)*	Vitals
Medication Allergies _____ _____ _____ Other Allergies *(e.g. dyes, contrast, latex)* _____ _____	_____ _____ _____ _____ _____ _____	Age _____ Height _____ Weight _____

Check all that apply in the sections below

Other Medical Conditions	*Past Surgeries*	*Family History of Illness*
☐ None ☐ Bleeding Disorder ☐ Glaucoma ☐ Diabetes ☐ Dialysis ☐ Stroke ☐ Thyroid Disease ☐ Sleep Apnea ☐ Asthma ☐ Heart Disease ☐ Malignant Hyperthermia ☐ Anesthesia Complications ☐ Cancer (of _____) ☐ Other (_____)	☐ None ☐ Tonsillectomy ☐ Adenoidectomy ☐ Thyroidectomy ☐ Ear Tubes ☐ Other Ear Surgery ☐ Sinus Surgery ☐ Nasal Septoplasty ☐ Carotid Artery Surgery ☐ Pacemaker ☐ Heart Bypass / Valve ☐ ACF (Anterior Cervical Fusion) ☐ Other (_____)	☐ None ☐ Malignant Hyperthermia ☐ Anesthesia Complications

How often do you drink alcohol?	*Cigarette or Cigar Smoking*	*Chewing Tobacco*
☐ Never ☐ Occasionally ☐ Weekly ☐ Daily	☐ Never used ☐ Past user ☐ Current user	☐ Never used ☐ Past user ☐ Current user

Patient (or Guardian) Signature _____ Date _____