IOWA ENT CENTER PLLC

REGISTRATION FORM

Acct#_____

Staff Initials _____

Provider_____

Name: _____
First Middle Last

Date of Birth: _____/_____/_____ **Sex:** ☐Male /☐Female **Marital Status:** ☐Single /☐Married /☐Widow /☐Divorced

Social Security#: _____/_____/_____ **Email address:** _____

Address: _____
Street or PO Box City State ZIP

Home Phone: (____) _____**Cell Phone:** (____) _____ **Work Phone:** (____)_____

Patient Employer: _____**Language:** _____ **Ethnic:** _____ **Race:** _____

Patient's Spouse: _____ **Spouse Employer:** _____ **Phone:** (____)_____

Referring Doctor: _____ **Family Doctor:** _____

Emergency Contact: _____Relationship:_____ Phone: (____)_____

****

Primary Insurance: _____ Name of Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

Secondary Insurance: _____ Name of Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____ Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

********** ***Please complete the following if the patient is a minor or full time student*** **********

Parent Name: _____Date of Birth: _____/_____/_____ Phone: (_____)_____

Address if different than patients: _____

Employer: _____ Employer Phone: (_____)_____

Parent Name: _____Date of Birth: _____/_____/_____ Phone: (_____)_____

Address if different than patients: _____

Employer: _____ Employer Phone: (_____)_____

How did you hear about our clinic? (Mark one box) ☐ Doctor ☐ Insurance Plan ☐ Family/Friend ☐ Yellow Pages/Internet

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Iowa ENT Center or its billing company to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____

IOWA ENT CENTER PLLC

_____

Patient Consent Form (HIPAA)

I understand 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 payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by Iowa ENT Center, PLLC and their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Iowa ENT Center, PLLC restricts how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that Iowa ENT Center, PLLC have taken action relying on this consent.

Patient's Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Kay Spear, Practice Manager
Iowa ENT Center, PLLC
105 Valley West Drive, Suite 100 West Des Moines, IA 50265-3939
(515) 223-4368 ext. 103

REQUEST FOR CONFIDENTIAL/ALTERNATE COMMUNICATIONS

Patient Information (Please Print)

Patient Name: **Last** **First** **Middle**

Date of Birth

I, the undersigned, hereby authorize Iowa ENT Center to discuss medical information concerning the above named patient to:

Name	**Relationship**	**Phone**

Medical information includes, but is not limited to demographic information, identification of providers of care, diagnosis, and procedures. This may relate to medical information, treatment and any billing information.

Please check all that apply:

☐ **You may contact me or leave a message/result for myself or my minor children at:**

Phone_____

Phone_____

Email_____

☐ **You may leave a message with a family member (Please specify):**

Name_____**Relationship**_____

Phone number _____

I understand that I may revoke this information at any time by sending a written notice to the office.

Signature: _____ Date: _____

Relationship if not the patient (if applicable): _____

Please note: this authorization does not provide the above named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.

IOWA ENT CENTER PLLC

Today's Date _____ Patient Name _____

Birth Date _____ Age _____ Occupation _____

Referring Physician or Family _____

Physician Date of last physical exam _____ Pharmacy _____

Medication Allergies: _____

Current Medications: _____

List your past illnesses: _____

Were you hospitalized for any of these illnesses?
If so, please give approximate date and problem:

_____

List your past surgeries: _____

Current Weight _____ Weight One Year Ago _____ Maximum Weight _____ When _____

Do you smoke ☐ Yes ☐ No How Much _____ Quit Date _____

Alcohol Consumption (circle one) ☐ none ☐ daily ☐ social ☐ occasional

Are you pregnant ☐ Yes ☐ No If so, how far along _____

Do you have or have you had any of the following: (please circle yes or no by each item)

Cardiovascular

High blood pressure	☐	Yes	No	☐
Low blood pressure	☐	Yes	No	☐
Coronary artery disease	☐	Yes	No	☐
Heart surgery (date)	☐	Yes	No	☐
Chest pain	☐	Yes	No	☐
Arrhythmia (irregular heart beat)	☐	Yes	No	☐
Rheumatic fever	☐	Yes	No	☐
Angioplasty (date)	☐	Yes	No	☐
High Cholesterol	☐	Yes	No	☐

Other _____

Pulmonary

Chronic obstructive lung disease	☐	Yes	No	☐
Pneumonia	☐	Yes	No	☐
Asthma	☐	Yes	No	☐
Chronic cough	☐	Yes	No	☐
Coughing up blood	☐	Yes	No	☐
Shortness of breath	☐	Yes	No	☐
walking several blocks	☐	Yes	No	☐
one flight of stairs	☐	Yes	No	☐
on lying down	☐	Yes	No	☐

Other _____

Upper Respiratory

Nasal septal deformity	☐	Yes	No	☐
Hayfever/Allergies	☐	Yes	No	☐
Chronic sinusitis	☐	Yes	No	☐
Sleep apnea	☐	Yes	No	☐
Sinus headaches	☐	Yes	No	☐
Nasal congestion	☐	Yes	No	☐
Change in voice	☐	Yes	No	☐
Change in smell	☐	Yes	No	☐
Hoarseness	☐	Yes	No	☐
Snoring	☐	Yes	No	☐
do you wake up frequently	☐	Yes	No	☐
stop breathing during sleep	☐	Yes	No	☐

Other _____

_____

_____

Constitutional

Fevers	☐	Yes	No	☐
Weight loss	☐	Yes	No	☐
Fatigue	☐	Yes	No	☐
Chills	☐	Yes	No	☐
Night sweats	☐	Yes	No	☐

Other _____

_____

_____

Neurological

Stroke/TIA	☐	Yes	No	☐
Bells Palsy	☐	Yes	No	☐
Migraine Headaches	☐	Yes	No	☐
Head Injury	☐	Yes	No	☐
Epilepsy	☐	Yes	No	☐
Meningitis	☐	Yes	No	☐
Headaches	☐	Yes	No	☐
Facial pain/paralysis	☐	Yes	No	☐
Weakness/Paralysis	☐	Yes	No	☐
Insomina	☐	Yes	No	☐

Other _____

_____

_____

Eye/Ear

Otitis media (ear infections)	☐	Yes	No	☐
Tinnitus (ringing in ears)	☐	Yes	No	☐
Menieres Disease	☐	Yes	No	☐
Ear Drainage	☐	Yes	No	☐
Dizziness	☐	Yes	No	☐
Hearing Loss	☐	Yes	No	☐
Earaches/Ear Pain	☐	Yes	No	☐
Double/Blurred Vision	☐	Yes	No	☐
Pain Behind Eyes	☐	Yes	No	☐

Other _____

_____

_____

Genitourinary

Kidney stones	☐	Yes	No	☐
Bladder/kidney infections	☐	Yes	No	☐
Frequent urination	☐	Yes	No	☐
Painful urination	☐	Yes	No	☐
Difficult urination	☐	Yes	No	☐

Other _____

_____

Musculoskeletal

Joint replacement	☐	Yes	No	☐
Arthritis	☐	Yes	No	☐
Broken bones	☐	Yes	No	☐
Joint pain	☐	Yes	No	☐

Other _____

_____

Gastrointestinal

Ulcers	☐	Yes	No	☐
Lesion of GI Tract	☐	Yes	No	☐
Colitis	☐	Yes	No	☐
Stomach Pain	☐	Yes	No	☐
Difficulty Swallowing	☐	Yes	No	☐

Other _____

_____

_____

Endocrine/Immune System

Diabetes	☐	Yes	No	☐
Hyperthyroidism (overactive)	☐	Yes	No	☐
AIDS/positive HIV	☐	Yes	No	☐
Enlarged Glands	☐	Yes	No	☐
Hypothyroidism (under active)	☐	Yes	No	☐
Autoimmune Disease	☐	Yes	No	☐

Other _____

Hematology

Hemophilia (bleeding disorder)	☐	Yes	No	☐
Blood Transfusion (list date)	☐	Yes	No	☐
Anemia	☐	Yes	No	☐

Other _____

Psychiatric

Mental Illness	☐	Yes	No	☐
Anxiety	☐	Yes	No	☐
Depression	☐	Yes	No	☐

Other _____

Past Illnesses

German Measles	☐	Yes	No	☐
Mumps	☐	Yes	No	☐
Syphilis/Gonorrhea	☐	Yes	No	☐
Hepatitis	☐	Yes	No	☐
Tuberculosis	☐	Yes	No	☐
Cancer	☐	Yes	No	☐

(if so, what type) _____

Other _____

Family History of the Patient

Father	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____
Mother	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____
Brother	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____
Brother	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____
Sister	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____
Sister	☐ Living	☐ Deceased	Age	_____	Cause of Death	_____

Has any immediate family member had any of the following? (Please circle all that apply)

Cancer (what type)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Early Hearing Loss	☐ Yes	☐ No	Problems with Anesthesia	☐ Yes	☐ No

Please give any other information that may be helpful in your treatment of care today.

Please Note

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

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