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

Name _____ **Family Physician** _____

Date of Birth _____ **Today's Date** _____

Current Medications

As Needed Medications (OTC and vitamins included)

Drug Allergies _____

_____

Non Drug Allergies _____

Birth Hospital _____

Born Full Term ☐ Yes/No ☐

NICU stay ☐ Yes/No ☐

Born at _____ weeks gestation

Current Ht: _____ Current Wt: _____

Preferred Pharmacy: _____

Ear History

Newborn Hearing Screening ☐ Pass /Fail ☐

School/AEA/Pediatrician Hearing Screen ☐ Pass /Fail ☐

Ear Infections ☐ Yes /No ☐

age of onset _____

how often _____

medications used _____

Previous Ear Surgery ☐ Yes /No ☐

Concern for Hearing Loss ☐ Yes /No ☐

Concern for Speech Delay ☐ Yes /No ☐

Family History of Early Onset Hearing Loss ☐ Yes /No ☐

if yes, please explain _____

Nasal/Sinus History

Congestion ☐ Yes/No ☐

Nasal Drainage ☐ Yes/No ☐

Chronic Cough ☐ Yes/No ☐

if yes, more often during ☐ Day/Night ☐

Headaches ☐ Yes/No ☐

Seasonal Allergies ☐ Yes/No ☐

allergy testing ☐ Yes/No ☐

family history of seasonal allergies ☐ Yes/No ☐

Eczema ☐ Yes/No ☐

Nosebleeds ☐ Yes/No ☐

if yes, how frequent _____

Oral/Throat History

Recurrent infections/sore throats ☐ Yes /No ☐

strep swab positive ☐ Yes /No ☐

Snoring ☐ Yes /No ☐

Episodes of paused breathing during sleep ☐ Yes /No ☐

if yes, what is the duration _____

Restless sleeper ☐ Yes /No ☐

Difficulty swallowing food ☐ Yes /No ☐

picky eater ☐ Yes /No ☐

Bad Breath ☐ Yes /No ☐

Airway History

Reactive airway disease/asthma ☐ Yes/No ☐

Describe symptoms _____

is it improving with time? ☐ Yes/No ☐

is it worse with feeding? ☐ Yes/No ☐

is child gaining weight? ☐ Yes/No ☐

Previous Chest Xray ☐ Yes/No ☐

Previous Swallow Study ☐ Yes/No ☐

Hospitalizations ☐ Yes/No ☐

ER Visits ☐ Yes/No ☐

phone:515.223.4368

www.iowaentcenter.com

General History

Previous Surgeries _____

_____

Previous Hospitalizations _____

_____

Behavioral, Mental, Sensory, Language or genetic diagnosis? ☐ Yes/No ☐

If yes, please specify:_____

What can we do or avoid to assist your child during this appointment?

_____

Gastrointestinal Problems ☐ Yes/No ☐

Fevers/Chills/Weight Loss ☐ Yes/No ☐

Kidney Problems ☐ Yes/No ☐

Neurological Problems

- balance issues ☐ Yes/No ☐
- head injury ☐ Yes/No ☐
- seizures ☐ Yes/No ☐

Immune/Endocrine Problems

- abnormal immune studies ☐ Yes/No ☐
- sweat chloride test ☐ Yes/No ☐
- HIV/HEP/TB ☐ Yes/No ☐
- family history of immune disorders ☐ Yes/No ☐
- diabetes ☐ Yes/No ☐

BLEEDING

- history of bleeding disorder ☐ Yes/No ☐

Social History

Father's Age	_____	Father's Health	☐ Good	☐ Fair	☐ Poor
Mother's Age	_____	Mother's Health	☐ Good	☐ Fair	☐ Poor
Brother's Age(s)	_____	Brother's Health	☐ Good	☐ Fair	☐ Poor
Sister's Age(s)	_____	Sister's Health	☐ Good	☐ Fair	☐ Poor

Breast fed or Bottle fed as infant _____

- how long? _____

Grade Level in School _____

Attends Daycare ☐ Yes/No ☐

- in home or center? _____

Second Hand Smoke Exposure ☐ Yes/No ☐

Family History

Life threatening problems with Anesthesia ☐ Yes/No ☐

Bleeding Disorders ☐ Yes/No ☐

Hearing Loss ☐ Yes/No ☐

Malignant Hyperthermia ☐ Yes/No ☐

Other _____

Other Speciality Physicians Your Child May See

please list physician name and their speciality

Thank you for taking the time to complete this information for your child.