IOWA ENT CENTER

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

_____

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

IOWA ENT CENTER PLLC

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

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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