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 ☐ 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

IOWA ENT CENTER PLLC

REQUEST FOR CONFIDENTIAL/ALTERNATE COMMUNICATIONS

Patient information (please print):

_____

Last Name First Name Middle Name

Birth date: _____ /_____ /_____

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 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: _____

☐ **I decline to have any medical information released and/or shared.**

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

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.

Signature: _____ **Date:** _____ /_____ /_____

Relationship (if not the patient): _____

105 Valley West Drive
West Des Moines, IA 50265
(515) 223-4368

319 N. Ankeny Blvd.
Ankeny, IA 50023
(515) 223-4368

405 Monroe Street, Suite A
Pella, IA 50219
(641) 628-9500

iowaENTcenter.com

IOWA ENT CENTER PLLC

ADULT HISTORY & PHYSICAL

Today's date: _____ /_____ /_____ **Patient name:** _____

Birth date: _____ /_____ /_____ **Age:** _____ **Occupation:** _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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? ☐ Yes ☐ No

If so, please give approximate date and problem: _____

List your past surgeries: _____

Current weight: _____ **Weight one year ago:** _____ **Maximum weight:** _____ **When?** _____

History of tobacco use? ☐ Yes, currently ☐ Yes, formerly ☐ No, never

How much? _____ Quit date: _____ /_____ /_____

History of vaping? ☐ Yes, currently ☐ Yes, formerly ☐ No, never Quit date: _____ /_____ /_____

Alcohol consumption: ☐ None ☐ Occasionally ☐ Socially ☐ Daily

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

Do you have or have you had any of the following?

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: _____

IOWA ENT CENTER PLLC

ADULT HISTORY & PHYSICAL

Do you have or have you had any of the following?

Upper respiratory

Nasal septal deformity	☐ Yes	☐ No
Hay fever/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
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
Bell's 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
Ménière's 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
Hypothyroidism (underactive)	☐ Yes	☐ No
AIDS/HIV-positive	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No

Other: _____

Hematology

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

Other: _____

Psychiatric

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Other: _____

Tuberculosis	☐ Yes	☐ No

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ADULT HISTORY & PHYSICAL

Do you have or have you had any of the following?

Past illnesses

German measles	☐ Yes	☐ No
Mumps	☐ Yes	☐ No
Syphilis/gonorrhea	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Cancer ☐ Yes ☐ No

If so, what type: _____

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?

Cancer	☐ Yes	☐ No	Thyroid/parathyroid issues	☐ Yes	☐ No
What type: _____			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: _____

_____

_____

_____

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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West Des Moines, IA 50265
(515) 223-4368

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