CHILDREN'S EAR, NOSE & THROAT SPECIALISTS

PATIENT REGISTRATION

Patient Name		<u> </u>		oes By	
LAST Address	FIRST	MIDDLE		SS#	
City					e
Home # ()				Gender:	M F Age
Email Address:					
Has any family member been seen l					
Emergency Contact: Name					
		CE INFORMATIO			
Primary		Secondary			
Policy ID #		_ Policy ID #			
Group # (if applicable)					
Subscriber Name		_ Subscriber Name	e		
Subscriber DOB					
Subscriber SS#		_ Subscriber SS# _			
Patient Relation to Subscriber					
	ENT/GUARDIAN RE				
Name					
Address (if different from patient)		ion to runont	Phone #	()	
City	State	Zin	Birth Da	te	Age
Employer	State		Work # ()		
Name	Relat	ion to Patient			
Address (if different from patient)					
City Employer List any additional people that h	State	Zip	Birth Da	te	Age
Employer			Work # ()_	· C	1.21.4.
List any additional people that h	ave your permission	on to seek medica	ıl treatment/serv	ices for y	our chiia:
I hereby authorize Children's Ear, Nose & carriers and other health care providers/fa that I have been offered/received a Privac provided to me or my dependents. I under provider. If my insurance company refus authorization for such services was not obto of my office visit and/or surgery.	cilities concerning my il by Notice from the Practic rstand that I am responsil	Iness and treatments, concerning to the for any charges not that I am responsible that I am responsible.	the Practice all pays covered by insurance of for any charges in	nents for med e, managed on e, curred in the	ical and surgical service are, government, or othe e event that proper prio
			Date		

Asthma Y N Feeling of a lump in the throat Y Chronic cough Y N Frequent stomach aches Y Genitourinary Sour taste in the mouth when waking up	What is the name and address who asked you to bring your cl		us?			What is the name and add	ress of your pedia	trician?	
Please check any medical problems that run in your family. (family history) Bar Infections	Please list any medical problems your child sees a doctor for.				Please list any surgeries your child has had in the past.				
Bar Infections	Please list the medications you	r child is	taking.			Please list any allergies you	ur child has to med	lication.	
Bar Infections									
Asthma Diabotes Cancer Cancer Cancer Cystic Fibrosis Thyroid Disease Asthma Diabotes Immune Disorders Hearing loss Social History Syour child in day care? Y N N Sickle Cell Disease Cieft Lip/Palate Social History Syour child was a pacifier? Y N N Number of older brothers / sisters at home? / Does/Did your child use a pacifier? Y N Number of older brothers / sisters at home? / Doy ou have any pets? Y N N Number of older brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N N Number of younger brothers / sisters at home? / Doy you have any pets? Y N Number of younger brothers / sisters at home? / Doy you have any pets? Y N Number of younger brothers / sisters at home? / Doy you have any pets? Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of younger brothers / sisters at home? / Preylife the systems Y N Number of policy file the systems	Please check any medical prob			your fa	mily. (family history)			
Astima	Ear Infections	Heart Dis	sease			Easy Bleeding/Bruising			
Astlmma	Allergies/Hay Fever	Cancer		-		Cystic Fibrosis	Thyroid Disease	•	
Social History Syour child in day care? Y N N Number of older brothers / sisters at home? /		Diabetes				Immune Disorders			
Social History Syour child in day care? Y N N Number of older brothers / sisters at home? Y N Number of older brothers / sisters at home? Y N Number of younger brothers / sisters at home? Y N	Acid Reflux	Kidney I	Disease		-	Sickle Cell Disease	Cieft Lip/Palate		
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Does/Did your child use a pacifier?									
Do you have any pets? Review of Systems Does your child currently have any of the following problems? General Weight Loss/Failure to gain weight Y N N Eczema Y N Neurological Recurrent Fevers Y N Neurological Recurrent Fevers Y N Neurological Recurrent Fevers Y N N Seizures Psychiatric Itchy Eyes Y N Depression Endocrine Hearing loss Y N Depression Fragenacy Y N Pregnancy Y N Pregnancy Y N Musculoskeletal Bedwetting Restless sleep Y N Hematological Frequent sneezing Itchy nose Y N Hematological Frequent sneezing Itchy nose Y N Recurrent Nose Bleeds Y N Recurrent Nose Bleeds Y N Recurrent Nose Bleeds Y N Restless fleeds Y N							_		
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