CHILDREN'S EAR, NOSE & THROAT SPECIALISTS

PATIENT REGISTRATION

Patient Name _____ Goes By _____
LAST FIRST MIDDLE

Address _____ SS# _____

City _____ State _____ Zip _____ Birth Date _____

Home # ( )_____ Cell ( )_____ Gender: M F Age _____

Email Address: _____

Has any family member been seen here before? Y N Name(s) _____

Emergency Contact: Name _____ Phone ( )_____

INSURANCE INFORMATION

Primary _____ Secondary _____

Policy ID # _____ Policy ID # _____

Group # (if applicable) _____ Group # (if applicable) _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Subscriber SS# _____ Subscriber SS# _____

Patient Relation to Subscriber_____ Patient Relation to Subscriber_____

PARENT/GUARDIAN RESPONSIBLE PARTY INFORMATION

Name _____ Relation to Patient _____ SS# _____

Address (if different from patient) _____ Phone # ( )_____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Employer _____ Work # ( )_____

Name _____ Relation to Patient _____ SS# _____

Address (if different from patient) _____ Phone # ( )_____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Employer _____ Work # ( )_____

List any additional people that have your permission to seek medical treatment/services for your child:

_____

I hereby authorize Children's Ear, Nose & Throat Specialists, PLLC (the "Practice") to furnish information to and obtain information from insurance carriers and other health care providers/facilities concerning my illness and treatments, consistent with the Privacy Notice provided. I acknowledge that I have been offered/received a Privacy Notice from the Practice. I hereby assign to the Practice all payments for medical and surgical services provided to me or my dependents. I understand that I am responsible for any charges not covered by insurance, managed care, government, or other provider. If my insurance company refuses payment, I understand that I am responsible for any charges incurred in the event that proper prior authorization for such services was not obtained. I understand that further non-emergent care may be denied if my account is not paid in full at the time of my office visit and/or surgery.

Signature _____ Date _____

NAME DATE
AGE MR

What is the name and address of the doctor who asked you to bring your child to see us?

What is the name and address of your pediatrician?

Please list any medical problems your child sees a doctor for.

Please list any surgeries your child has had in the past.

Please list the medications your child is taking.

Please list any allergies your child has to medication.

Please check any medical problems that run in your family. (family history)

Ear Infections		Heart Disease		Easy Bleeding/Bruising		Problems with Anesthesia	
Allergies/Hay Fever		Cancer		Cystic Fibrosis		Thyroid Disease	
Asthma		Diabetes		Immune Disorders		Hearing loss	
Acid Reflux		Kidney Disease		Sickle Cell Disease		Cieft Lip/Palate	

Social History

Is your child in day care? Y N
Is your child exposed to tobacco smoke? Y N
Does/Did your child use a pacifier? Y N
Do you have any pets? Y N

Is/Was your child breast fed? Y N For How Long? _____
Number of older brothers / sisters at home? _____/_____
Number of younger brothers / sisters at home? _____/_____
DOG CAT OTHER_____ INDOOR OUTSIDE

Review of Systems **Does your child currently have any of the following problems?**

General
- Weight Loss/Failure to gain weight Y N
- Night Sweats Y N
- Recurrent Fevers Y N

Eyes
- Itchy Eyes Y N
- Watery Eyes Y N

ENT
- Hearing loss Y N
- Snoring Y N
- Apnea(stops breathing at night) Y N
- Bedwetting Y N
- Restless sleep Y N
- Daytime sleepiness Y N
- Gasping/Choking during sleep Y N
- Mouth breathing during the day Y N
- Frequent sneezing Y N
- Itchy nose Y N
- Frequent/Chronic clear nasal drainage Y N
- Chronic green/yellow nasal drainage Y N

Cardiac
- Heart Murmur Y N
- Need for antibiotics prior to surgical (dental) procedures Y N

Respiratory
- Asthma Y N
- Chronic cough Y N

Genitourinary
- Recurrent urinary tract infections Y N

Skin
- Eczema Y N

Neurological
- Seizures Y N

Psychiatric
- Anxiety Y N
- Depression Y N

Endocrine
- Excessive tiredness Y N
- Pregnancy Y N

Musculoskeletal
- Joint pain/stiffness Y N

Immunologic
- Recurrent infections Y N
- Allergies Y N

Hematological
- Easy Bleeding/Bruising Y N
- Past blood transfusions Y N
- Recurrent Nose Bleeds Y N

Gastrointestinal/GERD
- Heartburn Y N
- Pain with swallowing Y N
- Coughing/Choking with swallowing Y N
- Frequent vomiting Y N
- Hoarseness Y N
- Feeling of a lump in the throat Y N
- Frequent stomach aches Y N
- Sour taste in the mouth when waking up Y N
- Frequent throat clearing Y N