Dwight Ellerbe, MD, FACS, FAAS | James Kallman MD, FACS | Stephen Schaffer, MD, FACS | Mark Lorenz, MD

Staci Johnson, ANP | Kaylyn Hum, AuD | Jamie Burford AuD | Stefan Harris, BC-HIS | Elise Blomfield, RN | Loduska Kirchner, RN | Audra McKellar, Esthetician

PATIENT REGISTRATION

In order to serve you properly we require the following information. Please COMPLETE ALL Sections. ***(PLEASE PRINT)***

Patient Information:

First Name: ______ M.I. ______ Last Name: ______

Mailing Address: ______

City: ______ State: ______ Zip Code: ______

Home#: ______ Cell#: ______ Work#: ______

Birth Date: ______ Gender: ☐ Male ☐ Female Preferred Language: ______

Marital Status: ______ Email: ______

SSN#: ______ Would you like us to email you our latest newsletter? Y ☐ N ☐

Employer: ______ Preferred Contact *(circle one)*: Home Phone | Cell Phone | Work Phone

Occupation: ______ Referring Physician: 1. ______ 2. ______

Please check below all boxes that apply to you:

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined ☐

Race: American Indian ☐ Alaska Native ☐ African American ☐ Asian ☐

Caucasian ☐ Hawaiian/Pacific Islander ☐ Other Race ☐ Declined ☐

Please check below all boxes that apply to you:

Employed ☐ Minor ☐ Retired ☐ Disabled ☐ Full-Time Student ☐ Unemployed ☐ Other ☐

Parent/Legal Guardian Information: (If patient is a minor or disabled)

Full Name: ______ Relationship to Patient: ______

Address: ______ City: ______ State: ______

Birth Date: ______ Phone: ______

SSN#: ______ Employer: ______ Work Phone: ______

Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: ______

Subscriber's name: ______ Birth Date: ______

SSN#: ______ Subscriber's Relationship: ______

Employer name: ______ Type of Plan *(circle one)*: Actively Employed | Retiree Plan | COBRA

Secondary Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: ______

Subscriber's name: ______ Birth Date: ______

SSN#: ______ Subscriber's Relationship: ______

Employer name: ______ Type of Plan *(circle one)*: Actively Employed | Retiree Plan | COBRA

Emergency Contacts:

Name: ______ Name: ______

Contact#: ______ Contact#: ______

Relationship to Patient: ______ Relationship to Patient: ______

Would you like your emergency contact person to be able to discuss your medical information and/or billing account?
Yes ( ) No ( )

Authorization and Assignment

I assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to ACENT. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. **I understand that I am financially responsible for all charges incurred from medical treatment at ACENT, whether or not the services are paid by my insurance.** If, for any reason, it becomes necessary for ACENT to engage an attorney or collections agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees, and collection costs.

Signature: ______ Date: ______

NAME____DATE_____________________

WHAT BRINGS YOU TO OUR OFFICE TODAY?

____

ARE YOU OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (check all that apply)

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Other Heart Problems
  Specify: ________________
- ☐ Asthma
- ☐ Other Lung Problems
  Specify: ________________
- ☐ Diabetes
- ☐ Thyroid Problems
  Specify: ____________
- ☐ Skin Cancer
- ☐ Skin Problems-Specify: ___________________
- ☐ Hearing Loss
- ☐ Hearing Aid
- ☐ Other Cancer-Specify: ___________________
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Kidney Problems
- ☐ HIV
- ☐ Hepatitis
- ☐ Depression
- ☐ Anxiety
- ☐ Allergies/Hayfever
- ☐ Sinus Problems-Specify: _______________
- ☐ Stomach Problems-Specify: _____________
- ☐ Obstructive Sleep Apnea
- ☐ Other (list)___________________________

PAST SURGERIES (list surgery, approximate date)

____

____

____

HAVE YOU RECEIVED ANY OF THE FOLLOWING?

- ☐ Flu Vaccine (over 50 years of age) Year:_____________
- ☐ Pneumonia Vaccine (over 50 years of age) Year:_____________
- ☐ Asthma Evaluation Year:_____________

☐ (Over the age of 60) Have you recently fallen? ☐ yes ☐ no

CURRENT MEDICATIONS & STRENGTH (prescription & over the counter)

____

____

____

____

ALLERGIES TO MEDICATIONS (list medication, reaction)

____

____

____

____

PRIMARY PHYSICIAN ________________________________

PHARMACY ____

FAMILY HISTORY (check all that apply)

- ☐ Hearing Loss
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Other Health Problems (list)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ None

____

____

____

SOCIAL HISTORY

Have you ever used tobacco? yes ☐ no ☐ quit date_____
Amount: _____packs/day for_____years
Type (circle one): cigarettes pipe chewing tobacco

Do you drink alcohol? yes ☐ no ☐
Amount: _____drinks per day/week/month

Do you drink caffeinated beverages? yes ☐ no ☐
Amount: _____cups or cans per day
Type: ☐ coffee ☐ tea ☐ soda ☐ energy drink

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (check all conditions that apply)

Constitutional
- ☐ fever
- ☐ pain
- ☐ weight loss/gain
- ☐ dizziness issues
- ☐ balance issues

Neurological
- ☐ headaches
- ☐ weakness
- ☐ numbness

Ears, Nose, Mouth, Throat
- ☐ hearing loss
- ☐ tinnitus/ringing in the ears
- ☐ nasal obstruction
- ☐ runny nose
- ☐ nosebleeds
- ☐ snoring
- ☐ sore throat
- ☐ lump in neck
- ☐ ear pain
- ☐ ear drainage

Cardiovascular
- ☐ chest pain
- ☐ shortness of breath
- ☐ palpitations

Respiratory
- ☐ cough
- ☐ hoarseness
- ☐ wheezing
- ☐ noisy breathing

Gastrointestinal
- ☐ heartburn
- ☐ throat clearing

Musculoskeletal
- ☐ muscle pain
- ☐ joint pain

Skin
- ☐ rash
- ☐ acne
- ☐ change in moles

Endocrine
- ☐ cold/heat intolerance
- ☐ night sweats

Allergic/Immunologic
- ☐ sneezing
- ☐ frequent infections

Eyes
- ☐ itching
- ☐ dryness
- ☐ excessive tearing

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3841 Piper Street, Ste T230 Anchorage, AK 99508 * www.acentalaska.com * (907)279-8800 12/21/15 KP