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: ______________

Hearing
AK Center for Ear Nose and Throat

NAME____ DATE__________

WHAT BRINGS YOU TO OUR OFFICE TODAY?

____

Complaining of: (check all that apply)

- ☐ Hearing Loss
- ☐ Dizziness/Unsteadiness
- ☐ Tinnitus (noise in ears)
- ☐ Ear Infections/Middle Ear Problems
- ☐ Feeling of fullness

In the last 90 days have you experienced

☐ Ear pain ☐ Ear drainage ☐ Sudden change in hearing

Have you seen a physician or ear specialist (ENT) in the last 6 months?

☐ Yes ☐ No If yes, please explain: ______________________________

CURRENT MEDICATIONS (prescription, herbal, OTC meds)

____

ALLERGIES TO MEDICATIONS (list medication, reaction)

____

Have you ever been treated for the following? (please check all that apply)

- ☐ Allergies
- ☐ Difficulty seeing at night
- ☐ Heart Defect
- ☐ Middle Ear Infections
- ☐ Skin tags on/near the ear
- ☐ Arthritis
- ☐ Ear Surgery
- ☐ High Blood Pressure
- ☐ Other Ear Malformations
- ☐ Two diff colored eyes
- ☐ Bones that break easily
- ☐ Eye Surgery
- ☐ Kidney Disease or Infection
- ☐ Patches of different colored skin
- ☐ Vision loss
- ☐ Cleft Palate
- ☐ Fainting Spells
- ☐ Measles
- ☐ Retinitis Pigmentosa (RP)
- ☐ Other: ______________
- ☐ Diabetes
- ☐ Head Injury/Unconsciousness
- ☐ Meningitis
- ☐ Scarlet Fever

PRIMARY PHYSICIAN ______________________________

PHARMACY ______________________________

Social History (please check all that apply)

- ☐ You avoid social occasions because you have difficulty hearing.
- ☐ You find yourself asking people to repeat themselves.
- ☐ You sometimes hear words but do not understand them.
- ☐ You have difficulty understanding people in noisy places.
- ☐ You have been told you speak loudly.
- ☐ Others complain of the T.V. being too loud.
- ☐ Some voices are easier to understand than others.

Do you have a family history of hearing loss at a young age?

☐ Yes ☐ No

Noise History:

☐ Military Experience ☐ Occupational ☐ Loud noise exposure in the last 14 hours ☐ Other: ______________

When in high noise areas, I use hearing protection:

☐ 0% (never) ☐ 25% ☐ 50% ☐ 75% ☐ 100% (Always)

Have you ever participated in the following?

- ☐ Chain Saw
- ☐ Dirt Bike
- ☐ Firearms
- ☐ Loud Music
- ☐ Lawn Equipment
- ☐ Other: ______________
- ☐ Wood working equipment

Left Ear Hearing Aid Make/ Model: ______________________________

Right Ear Hearing Aid Make/Model: ______________________________

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