ACENT
ALASKA CENTER FOR EAR NOSE AND THROAT

PATIENT REGISTRATION

Dwight Ellerbe, MD, FACS, FAAS | James Kallman MD, FACS | Stephen Schaffer, MD, FACS | Mark Lorenz, MD
taci Johnson, ANP | Nicole Tiefel, FNP | Kaylyn Hum, AuD | Caitlin Milligan,AuD | Stefan Harris, BC-HIS | Elise Blomfield, RN | Audra McKellar, Estheticia

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. _____

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

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American
☐ Hawaiian/Pacific Islander ☐ Caucasian ☐ 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:

Primary 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 | WorkComp

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 | WorkComp

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 t o 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?

_____

Did the child pass its Infant Hearing Screening at birth?

☐ Yes ☐ No ☐ Unknown

Were there any unusual complications/problems at birth?

☐ Yes ☐ No If yes, please explain: _____

Does the child experience ear infections?

☐ Yes ☐ No If yes, how often? Age of first infection, right ear, left ear or both:_____

CURRENT MEDICATIONS (prescription, herbal, OTC meds)

_____

_____

_____

ALLERGIES TO MEDICATIONS (list medication, reaction)

_____

_____

_____

Birth history (please check all that apply):

☐ Convulsions
☐ Difficulty breathing at birth
☐ Feeding difficulties
☐ Other_____

☐ Hemorrhage
☐ Incubator
☐ Infection / CMV

☐ Jaundice after 2-3 days
☐ Jaundice at birth
☐ Oxygen / ECMO

☐ Medications
☐ Transfusions

PRIMARY PHYSICIAN _____ **PHARMACY** _____

Behavioral / Hearing History (please check all that apply):

☐ You have concerns about your child's hearing.
☐ Does not respond appropriately to speech and noise.
☐ Speech / language has been evaluated.
☐ Has been identified with a speech / language delay or disorder.
☐ He / she has been enrolled in speech / language therapy.
☐ Has been exposed to loud noise. (i.e. loud music, gunfire, farm equipment)
☐ Other: _____

Has the child ever had:

☐ Adenoidectomy
☐ High Fevers

☐ Allergies
☐ Syndrome

☐ Ear Tubes
☐ Tonsillectomy

☐ Frequent Colds
☐ Other: _____

Hearing Aid or Cochlear Implant

☐ None ☐ Right Ear ☐ Left Ear ☐ Both Ears

Left Ear Hearing Aid Make/ Model:

_____

Right Ear Hearing Aid Make/Model:

_____

Dwight Ellerbe MD * James Kallman MD * Steve Schaffer MD* Mark Lorenz, MD *Kaylyn Hum, Au.D* Caitlin Milligan, Au.D , , Stefan Harris, BC-HIS*
3841 Piper St. Tower T - Suite 240 Anchorage, AK 99508 * www.acentalaska.com * (907)279-8800