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?

____

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:

____