



PATIENT REGISTRATION

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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 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)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stroke | Specify: _____ | | |
| <input type="checkbox"/> Other Heart Problems | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Allergies/Hayfever |
| Specify: _____ | <input type="checkbox"/> Skin Problems-Specify: _____ | | <input type="checkbox"/> Sinus Problems-Specify: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> HIV | <input type="checkbox"/> Stomach Problems-Specify: _____ |
| <input type="checkbox"/> Other Lung Problems | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Obstructive Sleep Apnea |
| Specify: _____ | <input type="checkbox"/> Other Cancer-Specify: _____ | | <input type="checkbox"/> Other (list) _____ |

PAST SURGERIES (list surgery, approximate date)

HAVE YOU RECEIVED ANY OF THE FOLLOWING?

- | | |
|--|-------------|
| <input type="checkbox"/> Flu Vaccine (over 50 years of age) | Year: _____ |
| <input type="checkbox"/> Pneumonia Vaccine (over 50 years of age) | Year: _____ |
| <input type="checkbox"/> Asthma Evaluation | Year: _____ |
| <input type="checkbox"/> (Over the age of 60) Have you recently fallen? <input type="checkbox"/> yes <input type="checkbox"/> no | |

CURRENT MEDICATIONS & STRENGTH (prescription & over the counter)

ALLERGIES TO MEDICATIONS (list medication, reaction)

PRIMARY PHYSICIAN _____

PHARMACY _____

FAMILY HISTORY (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> None |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Other Health Problems (list) | |
- _____
- _____

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 | Ears, Nose, Mouth, Throat | Cardiovascular | Gastrointestinal | Endocrine |
| <input type="checkbox"/> fever | <input type="checkbox"/> hearing loss | <input type="checkbox"/> chest pain | <input type="checkbox"/> heartburn | <input type="checkbox"/> cold/heat intolerance |
| <input type="checkbox"/> pain | <input type="checkbox"/> tinnitus/ringing in the ears | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> throat clearing | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> palpitations | | |
| <input type="checkbox"/> dizziness issues | <input type="checkbox"/> runny nose | | Musculoskeletal | Allergic/Immunologic |
| <input type="checkbox"/> balance issues | <input type="checkbox"/> nosebleeds | | <input type="checkbox"/> muscle pain | <input type="checkbox"/> sneezing |
| | <input type="checkbox"/> snoring | Respiratory | <input type="checkbox"/> joint pain | <input type="checkbox"/> frequent infections |
| Neurological | <input type="checkbox"/> sore throat | <input type="checkbox"/> cough | Skin | Eyes |
| <input type="checkbox"/> headaches | <input type="checkbox"/> lump in neck | <input type="checkbox"/> hoarseness | <input type="checkbox"/> rash | <input type="checkbox"/> itching |
| <input type="checkbox"/> weakness | <input type="checkbox"/> ear pain | <input type="checkbox"/> wheezing | <input type="checkbox"/> acne | <input type="checkbox"/> dryness |
| <input type="checkbox"/> numbness | <input type="checkbox"/> ear drainage | <input type="checkbox"/> noisy breathing | <input type="checkbox"/> change in moles | <input type="checkbox"/> excessive tearing |