PATIENT REGISTRATION FORM

NAME_____ _____**AGE**_____**DOB**_____ **SSN**_____

PHONE (HOME)_____**(WORK)**_____**(CELL)**_____

MAILING ADDRESS_____
STREET OR POB CITY/STATE ZIP

PATIENT EMPLOYER_____**EMAIL**_____

IF MINOR, PARENT NAME _____**DOB**_____

IN CASE OF EMERGENCY_____**PHONE**_____**RELATIONSHIP**_____

REFERRING OR PRIMARY PHYSICIAN_____

PRIMARY INSURANCE_____

ID#_____**GROUP**_____

SUBSCRIBER NAME_____**DOB**_____

SSN_____**EMPLOYER**_____

SECONDARY INSURANCE_____

ID_____**GROUP**_____

SUBSCRIBER NAME_____ _____**DOB**_____

SSN_____**EMPLOYER**_____

I hereby consent to MIDWEST ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the practice's healthcare operations. I understand that I have the right to request restrictions on how MIDWEST ENT uses and discloses my protected health information for treatment, payment or health care operations. MIDWEST ENT is not required to agree to any restriction, but should we; the restriction is binding to the practice. I have the right to revoke this consent in writing, except to the extent that MIDWEST ENT has taken action in reliance on this consent.

ALL CO-PAYMENTS, DEDUCTIBLES OR COINSURANCE ARE DUE AT TIME OF CHECK-IN. THERE WILL BE A $10 LATE FEE ADDED PER MONTH ON ALL BALANCES OVER 30 DAYS UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED.

_____ _____
Patient or Guardian Date

Patient History Form

Name:_____ **Sex:** M / F **Date of Birth:** _____ **Date:**_____

Phone: Home_____ Work_____ Cell _____

Referring MD: _____ **Primary MD:** _____

Reason for Visit: _____

Allergies to Medications (Include type of reaction): _____

_____

Medications (include over the counter):

_____
_____
_____
_____
_____
_____

Surgeries:

_____
_____
_____
_____
_____
_____

OTHER PROBLEMS: (Please Circle All That Apply):

EAR: Ear Infections Hearing Loss Ringing Dizziness Vertigo Ear Pain Ear Wax Ear Pressure Other: _____

NOSE: Sinus Infections Bleeding Congestion Sneezing Drainage Smelling Post Nasal Drip Other: _____

MOUTH: Pain Taste Dryness Lump Teeth Lips Other: _____

THROAT: Pain Tonsil Infection Swollen Tonsils "Lump in Throat" Snoring Hoarseness Swallowing Problem Sleep Problems Other: _____

NECK: Lump Pain Other _____

OTHER ALLERGIES (Please Circle): YES / NO Dust Mold Ragweed Pollen Pets Grass Trees Other _____

OTHER MEDICAL PROBLEMS (Please Circle All That Apply):

Heart Problems	Lung Problems	Bleeding Problems	Stomach Problems
Kidney Problems	Liver Problems	Eye Problems	Diabetes (high sugar)
Thyroid Problems	Skin Problems	Joint Problems	Immune Problems
Nerve Problems	Urinary Problems	Muscle Problems	Problems w/ Anesthesia
Stroke	Psychiatric Problems	HIV/AIDS	High Blood Pressure
Hepatitis A	Hepatitis B	Hepatitis C	

Other: _____

_____

ANY MEDICAL PROBLEMS RUN IN THE FAMILY: Blood Pressure Bleeding Problems Diabetes Anesthesia Problems Hearing or Ear Problems Other _____

TOBACCO USE (Please Circle): YES / NO Cigarettes Cigars Pipe Chewing Snuff E-cigarette

HOW MUCH? _____ **FOR HOW LONG?** _____

ALCOHOL USE (Please Circle): YES / NO **HOW MUCH?** _____ **FOR HOW LONG?** _____

OCCUPATION: _____ **MARITAL STATUS (Please Circle):** S M D W

OTHER INFORMATION: _____

MIDWEST EAR, NOSE & THROAT SURGERY

Midwest
EAR, NOSE & THROAT
SURGERY, PSC

CURRENT MEDICATIONS

DATE:		DATE:	

Message to our Patients

We file your insurance as a courtesy to you; **but you are expected to pay your co-insurance/co-payments/deductibles on the day of service. We accept cash, check, and credit cards.**

All patients under the age of eighteen (18) will need a parent in attendance or **legal guardian** with written authority to treat patient at the appointment before medical care can be provided.

If your insurance company requires **prior authorization** for you to see a specialist, please contact your insurance company or referring doctor, whichever is applicable, before your appointment and bring your prior authorization number and prior authorization form if required.

Medicare- We participates with Medicare using their guidelines. If you do not have a Medicare supplement the remaining **20% coinsurance** will be collected at time of visit.

Returned checks have a $50 handling fee added to the account.

Forms- There is a $20 fee for filling out forms. This includes FMLA forms.

It is the patient's responsibility to know what facilities and which physicians are providers of their insurance company network. You need to verify with your insurance company whether a referral or pre-certification is necessary. We will be happy to assist you as well to pre-certify a surgery; however it is your responsibility to know if it is actually a covered benefit with your member services.

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SIGNATURE DATE

DO YOU HAVE A COMMUNICABLE DISEASE TO REPORT TO THIS PHYSICIAN?

YES NO

SIGNATURE

MIDWEST EAR, NOSE, AND THROAT SURGERY

Patient Name:_____

Date of Birth: _____

Pharmacy:_____

Pharmacy Name:_____

Pharmacy Phone #:_____

Pharmacy Address:_____

Pharmacy Zip Code:_____