PATIENT REGISTRATION

(Please Print)

REFERRED BY: ____________________________________

PATIENT'S NAME: ____________________________________ AGE __________ BIRTHDATE __________

LAST FIRST MIDDLE

MALE __________ FEMALE __________ MARITAL STATUS ______________________________

PATIENT'S ADDRESS: ____

STREET CITY, STATE ZIP CODE

BILLING ADDRESS (if different from patient's address):

____

STREET CITY, STATE ZIP CODE

HOME PHONE ____________________________________ SOCIAL SECURITY NUMBER ____________________

EMPLOYER ____________________________________ WORK PHONE ______________________________

SPOUSE'S NAME ____________________________________ EMPLOYED BY ______________________________

IF SINGLE AND UNDER 21: FATHER'S NAME ____________________ EMPLOYED BY ________________________

MOTHER'S NAME ____________________ EMPLOYED BY ________________________

The Department of Health and Human Services has established a "Privacy Rule" (HIPPA) to help insure that personal health information is protected for privacy. As our patient we want you to know that we will comply fully with the Privacy Rule, and strive to always protect your privacy. When it is appropriate and necessary, we will provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. Our complete privacy policies are available for your review in our Reception area, in our Nurses' station, and also upon request from our front desk receptionist.

Signed (Patient, Parent, or Insured) ____ Date ____________________

INSURANCE INFORMATION:

SUBSCRIBER OF PRIMARY INSURANCE ______________________________ SUBSCRIBER'S BIRTHDATE ____________________

SUBSCRIBER OF SECONDARY INSURANCE ____________________________ SUBSCRIBER'S BIRTHDATE ____________________

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS SO THAT SHE CAN MAKE COPIES. THANK YOU.

EAR, NOSE AND THROAT ASSOCIATES OF BUTLER, LTD.
PATIENT HEALTH QUESTIONNAIRE
REVIEW OF SYSTEMS/PFSH
(TO BE UPDATED ONCE YEARLY)

PATIENT NAME____________________________________AGE ______VISIT DATE ____________

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? __ YES __ NO IF YES, PLEASE LIST **OR** GIVE YOUR LIST TO THE RECEPTIONIST TO COPY.

____

LATEX ALLERGY: __ YES __ NO

DO YOU **TAKE** ANY **PRESCRIPTION** MEDICATIONS REGULARLY? __YES __ NO IF YES, PLEASE LIST **OR** GIVE YOUR LIST TO THE RECEPTIONIST TO COPY.

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DO YOU TAKE ASPIRIN, NSAID, ARTHRITIS MEDICINE, COUMADIN, PLAVIX: __YES __ NO

DO YOU USE ANY TOBACCO PRODUCTS? __ YES __ NO HOW LONG? ______________
HOW MUCH PER DAY? ___________________________ QUIT HOW MANY YEARS AGO? ______

DO ***YOU*** SUFFER FROM ANY OF THE FOLLOWING PROBLEMS? (CHECK FOR YES ONLY)

__RHEUMATIC FEVER
__HEPATITIS
__HEART DISEASE
__LUNG DISEASE
__KIDNEY PROBLEMS
__THYROID DISEASE
__CANCER
__DIABETES
__HYPERTENSION
__ASTHMA
__HAY-FEVER
__OSTEOPOROSIS
__MIGRAINES
__MELANOMA
__OTHER____________________________________
__BLEEDING DISORDER
__REACTION TO ANESTHESIA
__GLAUCOMA
__EPILEPSY/SEIZURES
__HEARING LOSS
__PSYCHIATRIC DISORDER
__CHRONIC EAR INFECTIONS
__NONE

DO YOUR ***PARENTS, BROTHERS AND/OR SISTERS*** SUFFER FROM ANY OF THE FOLLOWING PROBLEMS? (CHECK FOR YES ONLY)

__RHEUMATIC FEVER
__HEPATITIS
__HEART DISEASE
__LUNG DISEASE
__KIDNEY PROBLEMS
__THYROID DISEASE
__CANCER
__DIABETES
__HYPERTENTION
__ASTHMA
__HAY-FEVER
__OSTEOPOROSIS
__MIGRAINES
__MELANOMA
__OTHER_____________________________________
__BLEEDING DISORDER
__REACTION TO ANESTHESIA
__GLAUCOMA
__EPILEPSY/SEIZURES
__HEARING LOSS
__PSYCHIATRIC DISORDER
__CHRONIC EAR INFECTIONS
__NONE

PLEASE LIST ANY PREVIOUS SURGERIES:
__NONE

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