

ENT Associates of Westerly, Ltd.
Welcome to our office

PATIENT REGISTRATION

FIRST NAME:	MI:	LAST NAME:
STREET ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE #:	WORK PHONE #:	
CELL PHONE#	EMAIL:	
DATE OF BIRTH:	AGE:	
	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>	
PATIENTS OCCUPATION:		
SPOUSE:		
PARENTS (if minor):		
PHARMACY/ADDRESS:		
REFERRING PHYSICIAN:		
PRIMARY PHYSICIAN:		
ALTERNATIVE CONTACT PERSON:		
RELATIONSHIP:	PHONE:	
CONTACT FOR EMERGENCY: YES/NO		
CONTACT FOR MEDICAL INFORMATION: YES/NO		

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized medical benefits be made on my behalf to ENT Associates of Westerly Ltd., for the services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurer; any information needed to determine these benefits payable to related services.

SIGNATURE _____ **DATE** _____

INSURANCE: _____

INSURANCE POLICY HOLDER: _____

POLICY #: _____

HISTORY (Answers to these questions are for our records only and will be confidential)

Have you had a recent exam? Yes _____ No _____ Date & Place: _____

Are you now under a Doctor's Care? _____

Have you been hospitalized within the past 5 years? Yes _____ No _____ Reason _____

Have you ever had an operation? Yes _____ No _____ If so, please list:

Do you smoke? Yes _____ No _____ How Much? _____

Do you drink? Yes _____ No _____ How Much? _____

Are you taking any medication now? Yes _____ No _____ Please List:

Are you allergic or sensitive to anything? Yes _____ No _____ Please List:

Are you on anti-coagulant therapy(blood thinner) Yes _____ No _____

Have you ever taken steroids (cortisone) Yes _____ No _____

Have You Ever Had:

Tuberculosis	Yes	No	Dizzy Spells	Yes	No
Heart Trouble	Yes	No	Swollen Ankles	Yes	No
Rheumatic Fever	Yes	No	Frequent Urination	Yes	No
Heart Murmur	Yes	No	Excessive Thirst	Yes	No
High Blood Pressure	Yes	No	Bloody Urine	Yes	No
Diabetes	Yes	No	Large Glands	Yes	No
Heart Attack	Yes	No	Muscle Weakness	Yes	No
Thyroid Trouble	Yes	No	Weight Loss	Yes	No

FAMILY HISTORY:

HAS ANY FAMILY MEMBER HAD:

Lung Trouble	Yes	No	Hearing Loss	Yes	No
Bowel Trouble	Yes	No	Dizzy Spells	Yes	No
Arthritis	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Heart Trouble	Yes	No
Venereal Disease	Yes	No	High Blood Pressure	Yes	No
Asthma(Hay Fever)	Yes	No	Diabetes	Yes	No
Glaucoma	Yes	No	Birth Defects	Yes	No
Headaches	Yes	No	Kidney Disease	Yes	No
Convulsions	Yes	No	Liver Disease	Yes	No
Bleeding Problems	Yes	No	Cancer	Yes	No
Shortness of Breath	Yes	No	Thyroid Cancer	Yes	No

WOMEN: Are you pregnant? Yes _____ No _____

Are you taking birth control pills? Yes _____ No _____

OTHER ILLNESS NOT SPECIFIED:

NAME: _____

DOB: _____

SIGNATURE: _____

DATE: _____

ENT ASSOCIATES
of WESTERLY, LTD.

J. I. Feldman, M.D., F.A.C.S.
Diplomate, American Board of Otolaryngology
Fellow, American Academy of Otolaryngology-
Head and Neck Surgery

D. S. Cameron, M.D., F.A.C.S.
Diplomate, American Board of Otolaryngology
Fellow, American Academy of Otolaryngology
Head and Neck Surgery

AUDIOLOGY DEPARTMENT
E. C. Carlson, M.S., CCC-A, FAAA
K. D. Dreher, M.S., CCC, FAAA

Head and Neck Surgery
Otology
Facial Plastic and Reconstructive Surgery
Thyroid and Parathyroid Surgery
Rhinology-Sinus Surgery
Pediatric Otolaryngology
Allergy
Audiology

ENT ASSOCIATES OF WESTERLY, LTD.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of ENT Associates of Westerly, Ltd.'s, Notice of Privacy Practices. This notice describes how ENT Associates of Westerly, Ltd. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient, or Guardian Date

Relationship to Patient

Patient refused to sign _____ Date: _____

Copy available at office if requested.