PATIENT REGISTRATION FORM

CAROLINA EAR, NOSE & THROAT

Last Name:___________________________ First:_____________________________ M.I.:___________
Sex:______ Age:_______ Date of Birth____/___/_____ Social Security # _______-_______-_______
Race:_______________ Ethnicity:________________________ Language Spoken:________________
If patient is child / under 18: Parent's Name____________________________ Child's Weight ____________
Home Address:___________________________________ City/State/Zip____________________________
Home Phone ( ) ______________ Cell ( ) ______________ Email___________________________
Employer: ____ Work Phone ( )_______________________
Employer Address:____
Pharmacy Name, Address & Phone:____

Please select how you would like to be contacted by our office: Home___ Cell____ Work____ Email____

Primary Care Physician __________________________ Referred by Dr.______________________________

How did you hear about us? Doctor Referral _____ Website_____ Patient_____ Other________

INSURANCE INFORMATION

Primary Insurance Company____________________________________ Policy #_______________________
Name of Insured:________________________________ Date of Birth:_________________________
Insured Employer:___________________________________ Social Security #___________________
Relationship to Patient:____

Secondary Insurance Company_________________________________ Policy #_______________________
Name of Insured:________________________________ Date of Birth:_________________________
Insured Employer:___________________________________ Social Security #___________________
Relationship to Patient:____

Carolina Ear, Nose & Throat will file insurance with contracted companies as a courtesy.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN IN ADVANCE WITH OUR OFFICE MANAGER.

I agree to be responsible for my medical expenses: therefore, I authorize my insurance company, attorney or other parties to pay directly to CAROLINA EAR, NOSE & THROAT and/or provide any information regarding payment of my bill, including appeals if necessary. I accept responsibility for any balance not paid by my insurance company if not paid in 45 days. I authorize Carolina Ear, Nose & Throat to release any medical information necessary as related to treatment or payment. I authorize the physician in charge to administer medical care as necessary, including release of X-rays or lab reports on my physical condition, to any party involved in my treatment. Photocopies of this form will be the same as original.

Signed:____ Date___________________

PAYMENT POLICY

To continue to offer the highest quality healthcare, Carolina Ear, Nose & Throat has a payment policy. We accept cash, check, credit cards and CareCredit.

You are expected to pay your insurance co-payment on the day of your appointment. You are also expected to pay ***in full*** any balance you have after the insurance has paid its portion. You will receive a statement of your account with the amount you are responsible for. If you are unable to pay ***in full*** with cash, check or credit card, you will be asked to set up a payment plan for a scheduled monthly payment due every 28 days.

There will be a $25 charge for missing your appointment or failing to cancel your appointment 24 hours beforehand.

There will be a $25 charge for any non-emergency after-hours phone call from the physician.

Carolina Ear, Nose & Throat

I have read and understand this payment policy.

____________________________________ ______________________

Signed Date

Diagnostic Procedures

Your physician may determine that he/she needs to perform a diagnostic endoscopy to see inside your nose / throat to fully evaluate your symptoms.

This type of in-office procedure is a separate charge that *is not* included with your office visit. Your insurance company will view this procedure as 'surgery' and will be listed as such on your EOB. All insurance plans are different so we have no way to determine how your insurance company will process and pay this claim according to your plan.

Although you have the right to refuse this procedure, we cannot be held responsible for any treatment we did not administer or recommend due to your refusal.

I have read and understand this diagnostic endoscopy policy.

_____________________________________ _______________________

Signed Date

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Carolina Ear, Nose & Throat/ Physician's Hearing Services may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Carolina Ear, Nose & Throat/ Physician's Hearing Services Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Carolina Ear, Nose & Throat/ Physician's Hearing Services reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carolina Ear, Nose & Throat, Attn: Lisa Hovey, at 10010 Falls of Neuse Road, Raleigh, NC 27614.

With my consent, Carolina Ear, Nose & Throat/ Physician's Hearing Services may call my home or other designated location and leave a message on voice mail / answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Carolina Ear, Nose & Throat/ Physician's Hearing Services may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements or insurance/billing information.

With my consent, Carolina Ear, Nose & Throat /Physician's Hearing Services may electronically send and receive information regarding my medication history with pharmacies.

We may disclose your PHI to others who may assist in your care, such as referring doctors, lab technicians, your spouse, children or parents, unless you object in writing.

I have the right to request that Carolina Ear, Nose & Throat/ Physician's Hearing Services restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Carolina Ear, Nose & Throat/ Med Facial of North Raleigh may decline to provide treatment to me.

By signing this form, I am consenting to Carolina Ear, Nose & Throat/ Physician's Hearing Services' use and disclosure of my PHI to carry out TPO.

______________________________	______________________________
Patient Name	Signature of Patient, Parent or Legal Guardian
______________________________	______________________________
Printed Name of Parent or Legal Guardian	Date

PATIENT HISTORY

Surgical History: ____

Current Medications: ____

Drug Allergies: ____

Have you been allergy tested? Yes No

Tested positive to____

Do you have or have you ever been diagnosed with:

Acid Reflux	Yes	No	Emphysema	Yes	No
Allergies / Hay Fever	Yes	No	Glaucoma	Yes	No
Arthritis	Yes	No	Heart Murmur	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No
Bleeding Disorder	Yes	No	Immune System Disease	Yes	No
Cancer	Yes	No	Migraines	Yes	No
Chest Pain/Heart Attack	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Thyroid Problems	Yes	No
Sleep Disorder	Yes	No			

Do you:

Use Alcohol: Yes No
Alcohol Type____________________
How Often______________________

Use Tobacco: Yes No
Type: Cigarettes Cigars Pipe Chew
Packs/ Number per Day______________________
Years of use________________________________

Consume Caffeinated Beverages: Yes No
Number of drinks per day__________________

FAMILY HISTORY

Asthma	Yes	No	Diabetes	Yes	No
Bleeding Disorder	Yes	No	Hay Fever/ Allergies	Yes	No
Cancer_____________	Yes	No	High Blood Pressure	Yes	No
Heart Disease	Yes	No	Other___________________________		

I consider myself generally: ____Healthy _____Chronic Issues ____Not Healthy

Please check all that apply

Ear, Nose & Throat	__Grind Teeth	__Heart Burn	__Sore Throat
__Ear Pain	__Runny Nose	__Tooth Pain	__Sores in mouth
__Pressure in ears	__Itchy Eyes/ Nose	__Difficulty Swallowing	__Snoring
__Hearing Loss	__Stuffy Nose	__Painful Swallowing	__Hoarseness
__Post Nasal Drip	__None	Other__________________________________	

Neurological (nerves)	__Twitching	__Ringing in Ears	__None of these
	__Abnormal Movements	__Dizziness/Vertigo	Other___________

Review of Systems

Circle any problems you are experiencing
Constitutional: fatigue, fever, frequent colds, weight gain(____lbs), weight loss(_____lbs)
Eyes: blurred vision, double vision, itching, burning, eye pain
Ears, Nose & Throat: sinus infection, cough, hoarseness, loss of hearing, nose bleeds, snoring
Cardiovascular: chest pain, irregular heartbeat, heart murmur
Lungs: wheezing, shortness of breath, coughing up blood/phlegm
Allergic/ Immunologic: seasonal allergies, hay fever
GI/ GU: vomiting, heartburn, loss of appetite, difficulty urinating
Musculoskeletal: muscle pain, joint pain/arthritis
Integumentary: rash, bruises easily
Neurologic: fainting, frequent headaches, seizures
Psychiatric: depression, anxiety
Endocrine: excessive thirst, excessive sweating
Hematologic/ Lymphatic: swollen glands
Other: pregnant