

Name: _____ ACCT# _____ Today's Date ___/___/20___

Metropolitan ENT & Facial Plastic Surgery REGISTRATION FORM

Please Print					PATIENT INFORMATION				
First Name		MI	Last Name		Date of Birth	Social Security #			
Address		Apt #	City		State	Zip			
Home Phone		Cell Phone		E-Mail Address (for confirming appointments)			Sex: (Circle) Male Female		
Employer Name			Occupation			Work Phone			
Status (Circle) Employed Unemployed Retired Student									
Emergency Contact Name			Emergency Contact Phone			Emergency Contact Relationship			
Marital Status: (circle one) Single Married Divorced Widow(er)			Primary Care Physician Name			Primary Care Physician Phone			
Same as above <input type="checkbox"/>					GUARANTOR/BILLING INFORMATION				
First Name		MI	Last Name		Date of Birth	Social Security #			
Address (if different then Pt)		Apt #	City		State	Zip			
Home Phone		Work Phone		Sex: (circle one) Male Female Marital Status: (circle one) Single Married Divorced Widow(er)					
Occupation			Name of Employer			Relationship to Patient			
Same as above <input type="checkbox"/>					PRIMARY INSURANCE POLICYHOLDER INFORMATION				
Insurance Company		Copayment		Policy Number/Group Number					
First Name		MI	Last Name		Date of Birth	Social Security #			
Address(if different then Pt)		Apt #	City		State	Zip			
Home Phone		Work Phone		Sex: (circle one) Male Female Marital Status: (circle one) Single Married Divorced widow(er)					
Occupation			Name of Employer			Relationship to Patient			

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Same as above <input type="checkbox"/> SECONDARY INSURANCE POLICYHOLDER INFORMATION				
Insurance Company		Copayment		Policy Number/Group Number
First Name	MI	Last Name	Date of Birth	Social Security #
Address	Apt #	City	State	Zip
Home Phone	Work Phone	Sex: (circle one) Male Female Marital Status: (circle one) Single Married Divorced Widow(er)		
Occupation		Name of Employer	Relationship to Patient	

Same as above <input type="checkbox"/> TERTIARY INSURANCE POLICYHOLDER INFORMATION				
Insurance Company		Copayment		Policy Number/Group Number
First Name	MI	Last Name	Date of Birth	Social Security Number
Address	Apt #	City	State	Zip
Home Phone	Work Phone	Sex: (circle one) Male Female Marital Status: (circle one) Single Married Divorced Widow(er)		
Occupation		Name of Employer	Relationship to Patient	

I, hereby authorize Metropolitan ENT & Facial Plastic Surgery/LMG to apply for benefits on my behalf for services rendered. I requested payment from the above indicated insurance carrier to be made directly to Metropolitan ENT. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any medical records necessary, including information for this or any related claim to the carriers indicated above.

I acknowledge and understand that I am financially responsible for my medical care. I agree to pay for services as they are provided, unless covered by contract between the provider and my insurance plan. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. I understand that if the insurance does not pay within 45 days, I will receive a bill and agree to ensure the insurance pays immediately or I will be responsible for the entire bill.

Unless otherwise instructed, Metropolitan ENT will assume that if you are married, we are authorized to disclose information about your care and benefits to your spouse (or parents, if you are a dependent child). If you disagree, please inform us immediately

Print Patient's Name _____

Signature _____ Today's Date ___/___/20___
Patient

Signature _____ Today's Date ___/___/20___
Parent/Guardian (Under 18 years of age)

PHARMACY INFORMATION		
PHARMACY Name	Phone #:	Fax #:

Name: _____ ACCT# _____ Today's Date ___/___/20___

Address:	City:	State:
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Are you Currently on Medications? No Yes (If yes, **PRINT CLEARLY** name and dosage)
(including natural, herbal and homeopathic medications)

MEDICATION NAME	DOSAGE	HOW OFTEN	REASON

Do you have any Drug Allergies? No Yes (If yes, please explain)

MEDICATION NAME	REACTION

Do you have any non-drug Allergies? No Yes (If yes, please explain)

NON-DRUG ALLERGIES	REACTION

Have you ever had surgery or been hospitalized? No Yes

Have you ever had problems with anesthesia? No Yes

Type of Surgery or Hospitalized	Date

Have you ever had a serious injury or accident? (Including bone fracture)?
 No Yes (If yes, please explain)

Type of Injury or Accident	Date

If female – Are you pregnant? No Yes

FAMILY & PATIENT HISTORY- Have you or anyone in your family had.... ?
 No Yes (If yes, please *CHECK ALL THAT APPLY*)

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	SELF	Family (PLEASE SPECIFY)		SELF	Family (PLEASE SPECIFY)		SELF	Family (PLEASE SPECIFY)
Alcoholism			Anemia			Angina/Heart Attack		
Arthritis			Asthma			Hay Fever		
Birth Defect			Bladder Disease			Bleeding Disorder		
Cancer (Type?)			Diabetes			Emphysema		
Epilepsy or Seizures			Glaucoma			Headache (Type?)		
HIV/AIDS			High Blood Pressure			Kidney Disease		
Liver Condition			Lung Condition			Mental Illness		
Stroke			Thyroid Condition			Tuberculosis		
Other (Type?)								

SOCIAL HISTORY (If Yes, please check all that apply)

Do you use tobacco? No Yes

___ No Longer ___ Cigarettes ___ Pipe ___ Cigars

Do you consume alcohol? No Yes

___ Beer ___ Wine ___ Coolers ___ Liquor

Do you use drugs recreationally? No Yes

___ Cocaine ___ Heroin ___ Marijuana ___ Oxycodine ___ Other

Do you use caffeine? No Yes

___ 1 per day ___ 2-3 per day ___ 4 or more

Do you have pets in the home? No Yes

___ Cat ___ Dog ___ Ferret ___ Gerbil ___ Hamster ___ Parakeet ___ Parrot ___ Rat

Patient considers diet to be: Healthy Not Healthy Other: _____

Do you exercise regularly? No Yes Type: _____

Home Living Situation? Alone w/Spouse w/Spouse & Children w/Children w/Parents

Other _____

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: Healthy Fair Not Healthy

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Eyes __ None	__ Double Vision __ Sensitivity to light __ Blurred Vision __ Itchy Eyes __ Other _____
Ears __ None	__ Hearing Loss __ Ringing in Ears __ Dizziness __ Draining __ Other _____
Nose __ None	__ Draining __ Itchy Nose __ Runny Nose __ Sneezing __ Snoring __ Nasal Congestion __ Nose Bleeds __ Other _____
Throat & Mouth __ None	__ Hoarseness __ Hives __ Voice Change __ Inflammation of Throat __ Popping sound in mouth or ear (TMJ) __ Sore Throat __ Sore Tongue __ Sores in Mouth __ Snoring __ swallowing difficulty __ ulcers Other _____
Cardiovascular (Heart and Blood Vessels) __ None	__ Black out __ Chest Pain __ Irregular Heartbeat __ Swelling Other _____
Respiratory (Lungs and Respiratory System) __ None	__ Cough, non-productive __ Cough, productive __ Coughing up Blood __ Pain or Tightness in chest __ Wheezing __ Sleep Disturbance due to breathing Other _____
Gastrointestinal (Stomach) __ None	__ Abdominal Pain __ Diarrhea __ Nausea __ Blood in stool Other _____
Genitourinary __ None	__ Urination at night Other _____
Musculoskeletal __ None	__ Loss of Muscle Strength Other _____
Integumentary (Skin) __ None	__ Bruises Easily __ Itching __ Dryness __ Moles that have changed __ Other _____
Neurological (Nerves) __ None	__ Numbness Other _____
Psychiatric __ None	__ Feels Sad more than usual __ Depression Other _____
Endocrine __ None	__ Appetite is increased __ Fatigue (excessive) __ Neck has enlarged __ Other _____
Hematologic __ None	__ Masses _____ Other _____
Allergic, Infections, Immune System __ None	__ Dark Circles under eyes __ Other __ Food intolerance __ Hives __ Itchy Nose __ Infections (recurring) __ Mouth Breathing