Tri-County Ear, Nose and Throat

Patient Registration

Patient Name: _____DOB: _____
(Last First Middle)

Phone: (Cell) _____ (work) _____ (home) _____

SS#: _____ Address: _____
(If Child- Parent's SS) *(Street City Zip)*

_____

Patient's e-mail Address: _____

Patient's Employer Name: _____

Primary Physician: _____ Referring Physician: _____

Responsible Party Name: _____ Relationship: _____

Pharmacy _____ Pharmacy Phone Number _____

Insurance Information

Insurance Carrier: _____ Insurance ID# _____

Address of Insurance Carrier: _____
(Street City Zip)

_____

Phone # of Insurance Carrier: _____

Subscriber Name (If different than the patient): _____

Relationship to Patient: _____ DOB: _____

Contact Information

Name: : _____

Contact Phone Home: _____ Contact Cell Phone _____

Contact Phone Work: _____ Relationship: _____

Is this visit accident related: Yes ____ No ____ Date of accident: _____

Type of Accident: Motor Vehicle _____ Work _____ School _____ Liability _____

Signatures

- I certify that the completed health and insurance information is true and accurate.
- I have read the fee policy of Tri-County Ear, Nose and Throat PC (TRIENT). I agree to be ultimately responsible for the balance on the account for services rendered. I consent to the diagnostic testing deemed necessary and authorize payment of medical benefits to TRIENT of supplier of services rendered.
- I acknowledge that I have been provided a copy of, or been offered the opportunity to receive from TRIENT notice of Privacy Practices (HIPAA).
- I authorize the release of my medical information to physicians, insurance companies and medical supplier and persons listed below other than immediate family members.
- I give permission for Tri County ENT to contact me via Text Message or Email.

_____ _____ _____
other person *other person* *other person*

_____ Date: _____
Patient or Patient Representative's (Print Name)

_____
Patient or Patient Representative's signature for all for the above

_____ Date: _____
Witness Signature

Tri-County Ear, Nose and Throat

Name: ***Date of Birth: _____/_____/_____***

Age: ***M / F*** ***Ht:*** ***Wt:*** ***Referring Physician:***

History of Present Illness: (What is the reason for today's visit?) (Duration of Problem?)

Is this a new complaint? Yes No ***Women: Are you or could you be pregnant? Yes No***

Medical History: (May use back.)

Medical Condition	*Date*	*Illness or Surgery*	*Date*
1)		*1)*	
2)		*2)*	
3)		*3)*	
4)		*4)*	
5)		*5)*	

Medications: ***(Give doses of all RX and OTC medications, vitamins & dietary supplements.) (May Use Back)***

1)	*6)*	*11)*
2)	*7)*	*12)*
3)	*8)*	*13)*
4)	*9)*	*14)*
5)	*10)*	*15)*

Allergies to Medicines: (Please specify reaction) ***Yes No***

1)	*4)*
2)	*5)*
3)	*6)*

Food Allergies: (Please specify reaction) ***Yes No***

Latex Allergy: ***Yes No***

Social History: ***(Circle) Single Married Divorced***
Occupation_____

Smoking (now) Yes No (Past) Yes No How much? _____ How many years? _____

(Circle) Cigarettes cigars pipe chewing tobacco recreational drugs

Alcohol Yes No What kind? _____ How much per day? _____ per week? _____

Family History: ***Diseases that run in your family (please circle)***

Diabetes Heart Disease Cancer High Blood Pressure Allergies Kidney Disease Hemophilia

Bleeding Disorders Thyroid Disease Hearing Loss Reactions to Anesthesia

Relationship	*Age*	*Condition*	*Alive/Deceased*	*Cause of Death*

	Do you have any of the following symptoms or problems? (Please Circle)
General:	Fever Chills Aches/Pains Memory Loss Nausea Vomiting Headaches
Skin:	Growths on face, neck or scalp? Yes No Any change in size? Yes No Bleeding? Yes No
Eyes:	Double Vision Wear Glasses Loss of Vision Cataracts Eye Pain Itchy Eyes
Ears:	Buzzing or Ringing Itching Pain Pressure Popping Drainage Dizziness Hearing Loss
	Do you wear hearing aids? R L Ear infections in last 12 months
	Noise Exposure Yes No Gun or Firearms use? Yes No Do you wear ear protection? Yes No
Nose:	Nasal Discharge (color: yellow green clear) Sinus Headaches Facial Pain Nosebleeds
	Difficulty breathing through nose? Yes No Nasal Fracture SNORING Mouth Breathing
Mouth:	Oral lesions Ulcers Bleeding gums Dental cavities Chipped or loose teeth
	Pain on opening/closing TMJ problems Bad breath Tongue pain Tongue lesions
Throat:	Sore throat Pain on swallowing Enlarged Tonsils Tonsil Infections Difficulty Swallowing
	Food getting stuck Lump sensation in throat Hoarseness Coughing up Blood
Neck:	Difficulty turning your neck Swollen Glands Lumps Pain
Lungs:	Asthma Emphysema Pneumonia Bronchitis Coughing SLEEP APNEA
Heart:	High Blood Pressure Chest Pain Murmur Valve Disease Heart Attack Cardiac Surgery/Stints
GI:	Heart Burn Hiatal Hernia Diarrhea Blood in Stool Ulcers Hepatitis Nausea/Vomiting
GU:	Urinary Tract Infections Burning Blood in Urine Kidney Stones
Blood:	Easy Bruising Bleeding Disorders Sickle Cell Trait/Disease Anemia
Musculoskeletal:	Broken bones Arthritis Loss of Muscle Strength Painful Joints Bad Back or Neck
Neurological:	Head Injury Concussion Stroke Mini-stroke Migraines Headaches Seizures Neuralgias
Psychological:	Depression Anxiety Mood Disorders Other Psychological Issues
Endocrine:	Diabetes Weight Gain/Loss Hot/Cold Intolerance Sweating Nervousness
	Thyroid/Parathyroid Disease Goiter/Thyroid Mass Thyroid Surgery Iodine Treatment Radiation Exposure
Other (comments and additions)	
Patient Signature:	Date: _____/_____/_____
(*for Office Use Only*)	
Notes:	