

## PATIENT REGISTRATION FORM

Today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email: \_\_\_\_\_

### PATIENT INFORMATION

Patient's last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  Mr.  Mrs.  Ms.

Marital status:  Single  Married  Divorced  Separated  Widowed

Language preferred: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Street address: \_\_\_\_\_ Social security no.: \_\_\_\_\_ Phone: \_\_\_\_\_

P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Doctor who referred you: \_\_\_\_\_ Primary doctor: \_\_\_\_\_

### INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Primary insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### PHARMACY INFORMATION

Name of primary pharmacy: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Street address: \_\_\_\_\_ Social security: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_  Able to release medical information including labs/pathways/imaging

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

**ASSIGNMENT OF BENEFITS:** The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mid-Valley ENT & Allergy or insurance company to release any information required to process my claims.

**AUTHORIZATION FOR RELEASE OF MEDICATION:** I authorize Mid-Valley ENT & Allergy to obtain my medication history from my pharmacy and/or referring physician.

Patient/guardian signature \_\_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**Albany Clinic:**  
950 29th Ave. SW  
Albany, OR 97321  
PHONE: 541-967-0404

**Newport Clinic:**  
1010 SW Hwy. 101  
Newport, OR 97365  
PHONE: 541-967-0331

### PATIENT MEDICAL HISTORY & PHYSICAL FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female Referred by: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you experience any hearing loss?  Yes  No

Do you experience any dizziness?  Yes  No Do you experience ringing or noise in your ears?  Yes  No

EAR	NOSE	ORAL/THROAT
Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N	Nasal Drainage <input type="checkbox"/> Y <input type="checkbox"/> N	Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> N
Decreased Hearing <input type="checkbox"/> Y <input type="checkbox"/> N	Nasal Obstruction <input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty Swallowing <input type="checkbox"/> Y <input type="checkbox"/> N
Ear Pain/Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	Decreased Sense of Smell <input type="checkbox"/> Y <input type="checkbox"/> N	Dry Mouth <input type="checkbox"/> Y <input type="checkbox"/> N
Ear Drainage <input type="checkbox"/> Y <input type="checkbox"/> N	Nasal Bleeding <input type="checkbox"/> Y <input type="checkbox"/> N	Throat Pain <input type="checkbox"/> Y <input type="checkbox"/> N
Ringing <input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Pain/Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	Snoring/Apnea <input type="checkbox"/> Y <input type="checkbox"/> N

List ALL Medical Problems Past and Present

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Medications: NONE or LIST ALL

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List ALL Past Surgeries

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Allergies to Medications: NONE or LIST ALL

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#### Social History/Habits

Tobacco Use:  Yes  No Cigarettes/Day: \_\_\_\_\_ Former Smoker:  Yes  No Years Smoked: \_\_\_\_\_ Year Quit: \_\_\_\_\_  
Tobacco Use in Other Forms: (please specify) \_\_\_\_\_

#### Family History – Please Identify All Medical Issues that BLOOD RELATIVES Have Had Past and Present:

Father:  Alive  Deceased  Unknown

Diabetes:  Y  N High Blood Pressure:  Y  N Heart Disease:  Y  N Mental Illness:  Y  N Cancer:  Y  N

Mother:  Alive  Deceased  Unknown

Diabetes:  Y  N High Blood Pressure:  Y  N Heart Disease:  Y  N Mental Illness:  Y  N Cancer:  Y  N

#### Are you CURRENTLY experiencing any of the following (please circle):

##### General:

Fatigue  
Fever  
Night Sweats  
Weight Loss

##### Allergy:

Post Nasal Drip  
Runny Nose  
Congestion  
Itchy Eyes/Nose/Throat

##### Eyes:

Blurred Vision  
Dry Eyes  
Itchy/Redness

##### Respiratory:

Asthma  
Cough  
Shortness of Breath

##### Cardiovascular:

Chest Pain  
Irregular Heartbeat

##### Gastrointestinal:

Heartburn/Reflux  
Nausea  
Vomiting

##### Hematology:

Bleeding Problems  
Easy Bruising  
Swollen Glands

##### Skin:

Eczema  
Hives  
Skin Cancer  
Skin Lesions

##### Neurologic:

Balance Difficulty  
Headache

Have you or a blood relative had either of the following: Anesthesia Problems  Y  N Bleeding Disorder  Y  N

Patient Signature

Dr. Signature

Date

## PATIENT RESPONSIBILITY DISCLAIMER FORM

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Patient/Responsible Party Signature

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Date

Thank you for choosing Mid-Valley ENT & Allergy/Hearing & Balance Center as your health care provider. We are committed to providing you with the highest quality health care. We ask that you read and sign to acknowledge your understanding of our patient financial policies.

### Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and up-to-date information regarding their insurance. Please provide BOTH primary insurance and secondary (if applicable) insurance. Some insurance companies only allow 90 days to bill before they deny a claim. If you give us the incorrect information and we are not able to bill before the 90-day period, the patient/responsible party will be responsible for any charges that are incurred.
- Patients are responsible for payment of co-pays, co-insurance and deductibles.
- **Co-pays are due at the time of service.**
- No valid referral/authorization from your primary care physician at the time of visit (some insurance companies require an authorization from your primary care physician or they will deny payment to us).
- Worker's Compensation claim in deferred or denied status.
- **For self-pay patients, payment will be collected at the time of service.**
- Managed care plans and HMO plans. These insurances require authorization before you can be seen by a specialist. It is your responsibility to know whether your insurance plan allows you to be seen by our providers at Mid-Valley ENT & Allergy/Hearing & Balance Center.
- Charges for returned checks.

**No-Show Policy:** As a courtesy, we agree to confirm your appointment by an automated reminder via email or call to your primary phone number one day before your scheduled appointment. You will, at that time, have the opportunity to cancel or confirm your appointment. **If you need to cancel or reschedule your appointment, we request a 24-hour advanced notice.** Early cancellation will allow us to give another person the possibility to have access to timely medical care. A "no-show" is a cancellation without calling to inform us ahead of time.

- **First no-show:** There will be no charge. We understand that there are circumstances (life happens) that could prevent you from showing up.
- **Second no-show:** A \$25 fee will be billed to your account and must be paid prior to your next appointment.
- **Third no-show:** A \$50 fee will be billed to your account and must be paid prior to your next appointment.
- **If you are 15 or more minutes late for a HEARING TEST APPOINTMENT, you may be rescheduled.**  
It is important that these appointments run on time.

**INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:**

I hereby authorize a direct payment of my medical benefits to Mid-Valley ENT & Allergy/Hearing & Balance Center on my behalf for any services furnished to me by the providers.

**AUTHORIZATION TO RELEASE RECORDS:**

I hereby authorize Mid-Valley ENT & Allergy/Hearing & Balance Center to release to my insurer, governmental agencies or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

**COMMUNICATION AUTHORIZATION:**

By my signature below, I authorize Mid-Valley ENT & Allergy/Hearing & Balance Center to communicate by mail, answering machine message and/or email according to the information I have provided in my patient registration information.

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Signature of Patient/Authorized Representative or Responsibly Party

Date

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Printed Name of Patient/Authorized Representative or Responsibly Party

Date

**For Patients 65 Years And Older**

Do you have an advance directive?  Yes  No

Do you have a living will?  Yes  No

Do you have an active DNR (do-not-resuscitate) order?  Yes  No



ENT Hearing & Balance Center

## ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I acknowledge that I have been informed of the office's Notice of Privacy Practices.

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(Please Print Name)

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(Signature)

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(Date)

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

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(Reason)

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(Employee Signature and Date)