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MISSOURI EAR, NOSE, AND THROAT CENTER

1000 W. Nifong Blvd.
Bldg. 3, Suite 100
Columbia, MO 65203

573-214-2000 ♦ 573-214-2042 (fax)

PATIENT REGISTRATION FORM

Patient name: _____
(Last) (First) (MI)

Address: _____

City, State, Zip: _____

Sex: Male O Female O Birth Date: _____ Email: _____

Social security # _____ Marital status: married/single/divorced/widowed

Primary Phone:_____ Secondary Phone:_____

Employer: _____ Occupation: _____

Ethnicity (circle): Hispanic Not Hispanic **Language (circle)**: English Spanish Other
Race (circle): Asian African American Hispanic Caucasian Other

☐ **Check if responsible party is same as above**

RESPONSIBLE PARTY OR BILL TO INFORMATION:

Full Name:_____ Relationship: _____

Address:_____

City: _____ State: _____Zip:_____

Home Phone: _____ Work/Cell Phone: _____

Social security # _____ Birth Date: _____ Age: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT NAME: _____ Relationship: _____

Home Phone:_____Work/Cell Phone: _____

INSURANCE: PLEASE PROVIDE ALL INSURANCE CARDS WHEN CHECKING IN

PREFERRED PHARMACY: _____ City/Town:_____

Please provide the name of your Primary Care Physician:

Dr:_____ Phone: (_____) _____

Did a doctor tell you to come in? If yes, what was the name of that doctor? _____

MISSOURI
EAR, NOSE, AND THROAT
CENTER

Authorization for Treatment and Financial Responsibility

Consent: I authorize my physician and other providers who may attend me, their associates and assistants to provide the medical care, tests, procedures and services considered advisable by my physician.

Storage and Release of Information: I consent to the electronic storage and transmission of patient health information. I hereby authorize Missouri Ear, Nose and Throat Center to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

- Any governmental or other entity as required by law for the purposes of reporting or purposes of determining eligibility in government sponsored benefit programs.
- The listed insurer(s) and/or agents of these companies.
- Any referring provider, continuing care, residential or long-term care facility or home health agency, hospital or surgery center where a procedure has been scheduled for the purpose of providing services for my care.

CommonWell and CareQuality Electronic Information Exchange: CommonWell and CareQuality interoperability hub provides access to medical information from healthcare facilities using Cerner and Epic electronic medical records. If you do not wish for Missouri ENT to have access to external medical records through this exchange, please notify our office.

Medicare Insurance Benefits: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related Medicare claim filed by my treating provider(s). I request that payment of authorized benefits be made on my behalf to my healthcare providers. I understand that I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered charges. I request payment of authorized Medigap benefits be made to this provider and also authorize the release to the named Medigap insurer any information needed to determine benefits payable to the provider.

Guarantee of Payment: In accordance with the above terms and in consideration of the services provided to the below named patient by Missouri Ear, Nose and Throat Center, the undersigned agrees, whether he/she signs as the patient or guarantor, to pay Missouri Ear, Nose and Throat Center for all services ordered by the providers, or requested by the patient and the patient's family. If requirements for referral, second opinion or precertification of care, as outlined by the insurer, benefit plan or other payor, have not been followed the patient and/or guarantor may, in some instances, be personally responsible for all charges incurred. If an account is forwarded to a collection agency for nonpayment the fees incurred will be charged to the guarantor of the account.

Assignment of Insurance Benefits: In consideration of any and all services furnished by Missouri Ear, Nose and Throat Center, I authorize direct payment to Missouri Ear, Nose and Throat Center of all insurance benefits applicable to services rendered by providers which are now or shall become due and payable to me.

Notice of Privacy Practices Acknowledgement of Receipt: I have received, or I have been provided the opportunity to receive a copy of the ***"Notice of Privacy Practices"*** that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Missouri Ear, Nose and Throat Center providers and staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Missouri Ear, Nose and Throat Center's operation and responsibilities.

I hereby authorize the following individual(s) to receive information regarding my medical condition(s) and related billing information:

_____ _____ _____

Do you have a Durable Power of Attorney (DPOA)? NO YES (Please enter name below)

Name of DPOA:_____

The undersigned certifies that the conditions of treatment have been read and understood. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute these conditions of treatment and accept the terms thereof.

_____

Signature of patient/person authorized to consent | Printed Name | Date

_____

Signature of Witness | Date

Patient Name:_____ **Date of Birth:**_____

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ Middle: _____

Social Security # _____ Date of Birth: _____/_____/_____ Age:_____

What is the reason for your visit today?

_____

_____

PAST MEDICAL HISTORY

List your present medications (include over the counter):

Medication	Dosage/Frequency	Medication	Dosage/Frequency

Are you on a blood thinner? Yes O No O If yes please list:_____

Indicate all past/present medical illnesses: **(Fill in the CIRCLE)**

	Yes	No		Yes	No
High Blood Pressure	O	O	Blood Clots	O	O
Heart Disease	O	O	Skin Cancer	O	O
Heart Attack	O	O	Arthritis	O	O
Diabetes	O	O	Anemia	O	O
Cancer	O	O	Lymphoma	O	O
Asthma	O	O	Leukemia	O	O
COPD(emphysema)	O	O	Reflux	O	O
Kidney Failure	O	O	Cholesteatoma	O	O
Stroke	O	O	Chronic Ear Infections	O	O

Please list any present/past medical illnesses not listed above:

_____ _____

_____ _____

_____ _____

For Females: Pregnant? Yes O No O **Breastfeeding?** Yes O No O

List all allergies (medication, food, etc.): Indicate reaction

_____ _____

_____ _____

_____ _____

List previous surgeries/hospitalizations:

Surgery (Indicated year)	Other Hospitalizations (Indicate Year)
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Do you have any blood relatives with:

	Yes	No	
Hearing loss before age 40	O	O	Relation to you: _____
Bleeding Disorder	O	O	Relation to you: _____
Heart attack before age 40	O	O	Relation to you: _____
Malignant Hyperthermia (life threatening reaction or anesthesia)	O	O	Relation to you: _____

Other: _____

SOCIAL HISTORY

Do you (adult):	Yes	No	
Smoke?	O	O	If yes, how many packs per day? _____
Drink?	O	O	If yes, <5, 5-10, or >10 drinks per week? (circle one)
Chew tobacco?	O	O	
Are you a previous smoker?	O	O	If yes, when did you quit? _____
Do you have a history of alcohol or substance abuse?	O	O	
Use of IV or other street drugs?	O	O	
If child:			
Does parent/caregiver smoke?	O	O	
Attend Day Care?	O	O	

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following? **Fill in Yes** or **No**:

Constitutional:	**Yes**	**No**
Weight Loss	O	O
Fatigue	O	O
Reduced Appetite	O	O

Eyes:	**Yes**	**No**
Blurred Vision	O	O
Double Vision	O	O
Other:_____		
_____		

Ears/Nose/Throat:	**Yes**	**No**
Hearing loss	O	O
Ringing in the ears	O	O
Noise exposure	O	O
Nasal obstruction	O	O
Sinusitis	O	O
Loss of smell	O	O
Hoarseness	O	O
Difficulty swallowing	O	O
Other:_____		
_____		

Cardiovascular:	**Yes**	**No**
Chest pain	O	O
Leg swelling	O	O
Heart murmur	O	O
Abnormal heart beat	O	O
Heart attack	O	O
Other:_____		
_____		

Respiratory:	**Yes**	**No**
Wheezing	O	O
Shortness of Breath	O	O
Asthma	O	O
COPD (emphysema)	O	O
Other:_____		
_____		

Gastrointestinal:	**Yes**	**No**
Indigestion/Heart burn	O	O
Stomach ulcers	O	O
Other:_____		
_____		

Genitourinary:	**Yes**	**No**
Dialysis	O	O
Other:_____		
_____		

Musculoskeletal:	**Yes**	**No**
Connect tissue disease	O	O
Cervical spine disease	O	O
Other:_____		
_____		

Skin:	**Yes**	**No**
Infection	O	O
Other:_____		
_____		

Neurological:	**Yes**	**No**
Numbness or weakness of face/extremity	O	O
Dizziness	O	O
Other:_____		
_____		

Psychological/Emotional:	**Yes**	**No**
Depression	O	O
Anxiety	O	O
Other:_____		
_____		

Endocrine:	**Yes**	**No**
Excessive thirst	O	O
Cold intolerance	O	O
Heat intolerance	O	O
Diabetes	O	O
Other:_____		
_____		

Hematologic/Lymphatic:	**Yes**	**No**
Bleeding Problems	O	O
Anemia	O	O
Other:_____		
_____		

Allergy/Immunologic:	**Yes**	**No**
Immune deficiency	O	O
Other:_____		
_____		

Patient/Guardian Signature: _____ Date: _____