REGISTRATION SLIP

Patient's Name D.O.B.

Address

City State Zip Phone

Cell Phone E-mail

❑ Single ❑ Married ❑ Widowed ❑ Divorced Social Security Number

Employer's Name

Employer's Address

City State Zip Employer's Phone

Emergency Contact Name Phone

Address City State Zip

Family Physician Phone

Address City State Zip

MUST BE COMPLETED WITH SPOUSE OR PARENT/GUARDIAN INFORMATION

Spouse Name Phone

Parent Name Phone

Address

City State Zip

D.O.B. Social Security# Relationship to Patient

Employer's Name Phone

Address City State Zip

INSURANCE INFORMATION

Primary Insurance Co. ❑ Medicare ❑ Medicaid ❑ BC/BS ❑ Other

Name of Policy Holder

I.D.# Group#

Address City State Zip

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other Policy Holder D.O.B.

Secondary Insurance Co. ❑ Medicare ❑ Medicaid ❑ BC/BS ❑ Other

Name of Policy Holder

I.D.# Group#

Address City State Zip

Patient Relationship to Policy Holder ❑ Self ❑ Spouse ❑ Child ❑ Other Policy Holder D.O.B.

Referred By:

I hereby give my permission to Bucks ENT Associates to disclose information regarding my treatment to:

❑ Spouse ❑ Son/Daughter ❑ Other ❑ Physician Name____

I do not give my permission to Bucks ENT Assoc. to disclose information regarding my treatment to:

❑ Spouse ❑ Son/Daughter ❑ Other ❑ Physician Name____

Over →

I hereby authorize and direct payment to BUCKS ENT ASSOCIATES for the surgical and/or Medical benefits, if any, otherwise payable to me under terms of my insurance. I will be personally responsible for payment if any service is determined to be non-covered, or denied by the third party payor. If invalid insurance is given resulting in non-payment I understand that I will be responsible for all balances incurred.

I hereby authorize BUCKS ENT ASSOCIATES to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to BUCKS ENT ASSOCIATES I hereby authorize photocopies of this form to be as valid as the original.

*Signature*____ *Date*_______________________

MEDICARE ONLY

*I request that payment of authorized Medicare Benefits be made to BUCKS ENT ASSOCIATES for any services. I authorize any holder of medical information about me to release to*______________________________________ *any information needed to determine these benefits payable for related services.*

I understand that if, under Medicare Program Guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand that I am financially responsible for any amount denied or partially paid by the third party payer.

*Signature*____ *Date*_______________________

Name ______________________________ D.O.B. ______________ Date ________

FOR FEMALES: Is there a possibility you are pregnant? Yes ☐ No ☐ Date of Last Period: ______________

Chief Complaint ____

PERSONAL HISTORY: Illnesses

	Yes	No
Measles	☐	☐
Mumps	☐	☐
Chicken Pox	☐	☐
Smallpox	☐	☐
Pneumonia	☐	☐
Heart Disease	☐	☐
Arthritis	☐	☐
Bone Disease	☐	☐
Polio/Meningitis	☐	☐
Gonorrhea/Syphillis	☐	☐
Gallbladder disease	☐	☐
Jaundice	☐	☐
Bladder disease	☐	☐
Epilepsy	☐	☐
Migraines	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
What type? ______________		
Colitis	☐	☐
Nervous Breakdown	☐	☐
Any poisoning	☐	☐
What type? ______________		
Asthma/Hay fever	☐	☐
Eczema/Hives	☐	☐
AIDS	☐	☐
High blood pressure	☐	☐
Blood transfusion	☐	☐

ALLERGIES:

	Yes	No
Penicillin	☐	☐
Sulfa	☐	☐
Aspirin/Codeine	☐	☐
Mycins	☐	☐
Methiolate	☐	☐
Tetanus/Serums	☐	☐
Adhesive Tape	☐	☐
Cosmetics	☐	☐

Any drug ______________________________

____

____

Any food ______________________________

____

INJURIES:

	Yes	No
Broken bones	☐	☐
Sprains	☐	☐
Lacerations	☐	☐
Concussion	☐	☐
Head injury	☐	☐

WEIGHT: ______________________

HEIGHT: ______________________

WITHIN THE LAST YEAR HAVE YOU HAD:

	Yes	No
Frequent headaches	☐	☐
Severe headaches	☐	☐
Dizziness	☐	☐
Blurred Vision	☐	☐
Spots before eyes	☐	☐
Infected eyes	☐	☐
Earaches	☐	☐
Ear discharge	☐	☐
Ringing in ears	☐	☐
Decrease hearing	☐	☐
Recurrent nose bleed	☐	☐
Recurrent head cold	☐	☐
Sinus trouble	☐	☐
Nasal odors	☐	☐
Strange taste	☐	☐
Loss in taste	☐	☐
Hoarseness	☐	☐
Persistent Difficulty Swallowing	☐	☐
Enlarged glands	☐	☐
Sore throats	☐	☐
Recurrent	☐	☐

	Yes	No
Chronic Cough	☐	☐
Coughed up blood	☐	☐
Coughing laying	☐	☐
Waking up short of breath	☐	☐
Purple fingers	☐	☐
Heart fluttering	☐	☐
Swelling hands	☐	☐
Swelling feet	☐	☐
Swelling ankles	☐	☐
Stomach pain	☐	☐
Recurrent	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Vomiting	☐	☐
Nausea	☐	☐
Vomiting blood	☐	☐
Abdominal cramping	☐	☐
Sores in mouth	☐	☐
Bleeding in gums	☐	☐
Sore gums	☐	☐
Chest pain		