IOWA ENT CENTER PLLC

# REGISTRATION FORM

Acct#____________

Staff Initials ______

Provider__________

**Name:** ______________________________________________________________________________
First Middle Last

**Date of Birth:** _______/_______/_______ **Sex:** Male / Female **Marital Status:** Single / Married / Widow / Divorced

**Social Security#:** _______/_______/________ **Email address:** ______________________________________________

**Address:** ______________________________________________________________________________
Street or PO Box City State ZIP

**Home Phone:** ( ____) ______________**Cell Phone:** (____) ________________ **Work Phone:** (____)____________________

**Patient Employer:** __________________________**Language:** ____________ **Ethnic:** _____________ **Race:** ____________

**Patient's Spouse:** _______________________ **Spouse Employer:** _____________________ **Phone:** (____)_____________

**Referring Doctor:** _________________________________ **Family Doctor:** ________________________________________

**Emergency Contact:** ______________________________Relationship:________________ Phone: (____)_____________

*******************************************************************************

**Primary Insurance:** _____________________________________ Name of Policy Holder: ____________________________

Date of Birth: _____/_____/_____ Relationship to Patient: ____________Employer: _______________________________

Insurance ID#: ________________________________ Group#: _______________________ Copayment: ______________

**Secondary Insurance:** ___________________________________ Name of Policy Holder: _____________________________

Date of Birth: _____/_____/_____ Relationship to Patient: ____________ Employer: _______________________________

Insurance ID#: ________________________________ Group#: ______________________ Copayment: _______________

************ ***Please complete the following if the patient is a minor or full time student*** *************

**Parent Name**: _______________________________Date of Birth: _____/_____/_____ Phone: (_____)_______________

Address if different than patients: _________________________________________________________________________

Employer: _____________________________________________________ Employer Phone: (_____)_________________

**Parent Name:** _______________________________Date of Birth: _____/_____/_____ Phone: ( _____)_______________

Address if different than patients: _________________________________________________________________________

Employer: _____________________________________________________ Employer Phone: (_____)_________________

How did you hear about our clinic? (Mark one box) ☐ Doctor ☐ Insurance Plan ☐ Family/Friend ☐ Internet

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 Iowa ENT Center or its billing company to release any information required to process my claims.

**Patient/Guardian Signature:** ________________________________________________ **Date:** _______________________

IOWA ENT CENTER PLLC

## Patient Consent Form (HIPAA)

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by Iowa ENT Center, PLLC and their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Iowa ENT Center, PLLC restricts how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that Iowa ENT Center, PLLC have taken action relying on this consent.

Patient's Name: ______________________________________________ Date: _______________________

Signature: __________________________________________________ Relationship to Patient: _______________

Kay Spear, Practice Manager

Iowa ENT Center, PLLC

105 Valley West Drive, Suite 100 West Des Moines, IA 50265-3939

(515) 223-4368 ext. 103

# REQUEST FOR CONFIDENTIAL/ALTERNATE COMMUNICATIONS

**Patient information (please print):**

_______________________________________________

Last Name | First Name | Middle Name

**Birth date:** _______ /_______ /_______

**I, the undersigned, hereby authorize Iowa ENT Center to discuss medical information concerning the above-named patient to:**

| Name | Relationship | Phone |
|---|---|---|
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |

Medical information includes, but is not limited to, demographic information, identification of providers of care, diagnosis, and procedures. This may relate to medical information, treatment, and billing information.

**Please check all that apply:**

☐ **You may contact me or leave a message/result for myself or my minor children at:**

Phone: ______________________________

Phone: ______________________________

Email: ______________________________

☐ **You may leave a message with a family member (please specify):**

Name: ______________________________ Relationship: ______________________________

Phone: ______________________________

☐ **I decline to have any medical information released and/or shared.**

I understand that I may revoke this information at any time by sending a written notice to the office.

Please note: This authorization does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.

**Signature:** ______________________________ **Date:** _______ /_______ /_______

**Relationship (if not the patient):** ______________________________

105 Valley West Drive
West Des Moines, IA 50265
(515) 233-4368

319 N. Ankeny Blvd.
Ankeny, IA 50023
(515) 233-4368

405 Monroe Street, Suite A
Pella, IA 50219
(641) 628-9500

iowaENTcenter.com

IOWA ENT CENTER PLLC

**ADULT HISTORY & PHYSICAL**

**Today's date:** _______ /_______ /_______ **Patient name:** ____________________________________________

**Birth date:** _______ /_______ /_______ **Age:** _______ **Occupation:** ____________________________________

**Marital status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

**Referring physician or family physician:** ____________________________________________

**Date of last physical exam:** _______ /_______ /_______ **Pharmacy:** ____________________________________

**Medication allergies:** ____________________________________________

**Current medications:** ____________________________________________

**List your past illnesses:** ____________________________________________

Were you hospitalized for any of these illnesses? ☐ Yes ☐ No

If so, please give approximate date and problem: ____________________________________________

**List your past surgeries:** ____________________________________________

**Current weight:** __________ **Weight one year ago:** __________ **Maximum weight:** __________ **When?** __________

**History of tobacco use?** ☐ Yes, currently ☐ Yes, formerly ☐ No, never

How much? ____________________________________________ Quit date: _______ /_______ /_______

**History of vaping?** ☐ Yes, currently ☐ Yes, formerly ☐ No, never Quit date: _______ /_______ /_______

**Alcohol consumption:** ☐ None ☐ Occasionally ☐ Socially ☐ Daily

**Are you pregnant?** ☐ Yes ☐ No If so, how far along? ____________________________________

**Do you have or have you had any of the following?**

**Cardiovascular**

| | | |
|---|---|---|
| High blood pressure | ☐ Yes | ☐ No |
| Low blood pressure | ☐ Yes | ☐ No |
| Coronary artery disease | ☐ Yes | ☐ No |
| Heart surgery (date) | ☐ Yes | ☐ No |
| Chest pain | ☐ Yes | ☐ No |
| Arrhythmia (irregular heart beat) | ☐ Yes | ☐ No |
| Rheumatic fever | ☐ Yes | ☐ No |
| Angioplasty (date) | ☐ Yes | ☐ No |
| High cholesterol | ☐ Yes | ☐ No |

Other: ______________________________

**Pulmonary**

| | | |
|---|---|---|
| Chronic obstructive lung disease | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Chronic cough | ☐ Yes | ☐ No |
| Coughing up blood | ☐ Yes | ☐ No |
| Shortness of breath | ☐ Yes | ☐ No |
| Walking several blocks | ☐ Yes | ☐ No |
| One flight of stairs | ☐ Yes | ☐ No |
| On lying down | ☐ Yes | ☐ No |

Other: ______________________________

IOWA ENT CENTER PLLC

## ADULT HISTORY & PHYSICAL

**Do you have or have you had any of the following?**

**Upper respiratory**

| | | |
|---|---|---|
| Nasal septal deformity | ☐ Yes | ☐ No |
| Hay fever/allergies | ☐ Yes | ☐ No |
| Chronic sinusitis | ☐ Yes | ☐ No |
| Sleep apnea | ☐ Yes | ☐ No |
| Sinus headaches | ☐ Yes | ☐ No |
| Nasal congestion | ☐ Yes | ☐ No |
| Change in voice | ☐ Yes | ☐ No |
| Change in smell | ☐ Yes | ☐ No |
| Hoarseness | ☐ Yes | ☐ No |
| Snoring | ☐ Yes | ☐ No |
| Wake up frequently | ☐ Yes | ☐ No |
| Stop breathing during sleep | ☐ Yes | ☐ No |

Other: ________________________________

**Constitutional**

| | | |
|---|---|---|
| Fevers | ☐ Yes | ☐ No |
| Weight loss | ☐ Yes | ☐ No |
| Fatigue | ☐ Yes | ☐ No |
| Chills | ☐ Yes | ☐ No |
| Night sweats | ☐ Yes | ☐ No |

Other: ________________________________

**Neurological**

| | | |
|---|---|---|
| Stroke/TIA | ☐ Yes | ☐ No |
| Bell's palsy | ☐ Yes | ☐ No |
| Migraine headaches | ☐ Yes | ☐ No |
| Head injury | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Meningitis | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Facial pain/paralysis | ☐ Yes | ☐ No |
| Weakness/paralysis | ☐ Yes | ☐ No |
| Insomina | ☐ Yes | ☐ No |

Other: ________________________________

**Eye/ear**

| | | |
|---|---|---|
| Otitis media (ear infections) | ☐ Yes | ☐ No |
| Tinnitus (ringing in ears) | ☐ Yes | ☐ No |
| Ménière's disease | ☐ Yes | ☐ No |
| Ear drainage | ☐ Yes | ☐ No |
| Dizziness | ☐ Yes | ☐ No |
| Hearing loss | ☐ Yes | ☐ No |
| Earaches/ear pain | ☐ Yes | ☐ No |
| Double/blurred vision | ☐ Yes | ☐ No |
| Pain behind eyes | ☐ Yes | ☐ No |

Other: ________________________________

**Genitourinary**

| | | |
|---|---|---|
| Kidney stones | ☐ Yes | ☐ No |
| Bladder/kidney infections | ☐ Yes | ☐ No |
| Frequent urination | ☐ Yes | ☐ No |
| Painful urination | ☐ Yes | ☐ No |
| Difficult urination | ☐ Yes | ☐ No |

Other: ________________________________

**Musculoskeletal**

| | | |
|---|---|---|
| Joint replacement | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No |
| Broken bones | ☐ Yes | ☐ No |
| Joint pain | ☐ Yes | ☐ No |

Other: ________________________________

**Gastrointestinal**

| | | |
|---|---|---|
| Ulcers | ☐ Yes | ☐ No |
| Lesion of GI tract | ☐ Yes | ☐ No |
| Colitis | ☐ Yes | ☐ No |
| Stomach pain | ☐ Yes | ☐ No |
| Difficulty swallowing | ☐ Yes | ☐ No |

Other: ________________________________

**Endocrine/immune system**

| | | |
|---|---|---|
| Diabetes | ☐ Yes | ☐ No |
| Hyperthyroidism (overactive) | ☐ Yes | ☐ No |
| Hypothyroidism (underactive) | ☐ Yes | ☐ No |
| AIDS/HIV-positive | ☐ Yes | ☐ No |
| Enlarged glands | ☐ Yes | ☐ No |
| Autoimmune disease | ☐ Yes | ☐ No |

Other: ________________________________

**Hematology**

| | | |
|---|---|---|
| Hemophilia (bleeding disorder) | ☐ Yes | ☐ No |
| Blood transfusion (list date) | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |

Other: ________________________________

**Psychiatric**

| | | |
|---|---|---|
| Anxiety | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No |

Other: ________________________________

**Tuberculosis** ☐ Yes ☐ No

IOWA ENT CENTER PLLC

## ADULT HISTORY & PHYSICAL

**Do you have or have you had any of the following?**

**Past illnesses**

| | | |
|---|---|---|
| German measles | ☐ Yes | ☐ No |
| Mumps | ☐ Yes | ☐ No |
| Syphilis/gonorrhea | ☐ Yes | ☐ No |
| Hepatitis | ☐ Yes | ☐ No |

**Cancer** ☐ Yes ☐ No

If so, what type: ________________________

**Family history of the patient**

Father: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

Mother: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

Brother: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

Brother: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

Sister: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

Sister: ☐ Living ☐ Deceased Age: _________ Cause of death: ____________________________________________

**Has any immediate family member had any of the following?**

| | | |
|---|---|---|
| Cancer | ☐ Yes | ☐ No |
| What type: ____________________________ | | |
| High blood pressure | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Early hearing loss | ☐ Yes | ☐ No |
| Thyroid/parathyroid issues | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Heart trouble | ☐ Yes | ☐ No |
| Hemophilia | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Problems with anesthesia | ☐ Yes | ☐ No |

**Please give any other information that may be helpful in your treatment:** ____________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.