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

IOWA ENT CENTER PLLC

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

PEDIATRIC HISTORY & PHYSICAL

Patient name: _____ **Family physician:** _____

Birth date: _____ /_____ /_____ **Today's date:** _____ /_____ /_____

Current medications: _____

As-needed medications (OTC and vitamins included): _____

Medication allergies: _____ **Non-medication allergies:** _____

Born full term: ☐ Yes ☐ No **NICU stay:** ☐ Yes ☐ No **Born at** _____ **weeks gestation**

Preferred pharmacy: _____ **Current height:** _____ **Current weight:** _____

General history

Previous surgeries: _____

Previous hospitalizations: _____

Behavioral, mental, sensory, or language concerns? ☐ Yes ☐ No If yes, please specify: _____

_____

What can we do or avoid to assist your child during this appointment? _____

_____

Ear history

Newborn hearing screening	☐ Pass	☐ Fail
School/AEA/pediatrician hearing screen	☐ Pass	☐ Fail
Ear infections	☐ Yes	☐ No
Age of onset	_____	
How many antibiotics used	_____	
Medications used	_____	
Previous ear surgery	☐ Yes	☐ No
Concern for hearing loss	☐ Yes	☐ No
Concern for speech delay	☐ Yes	☐ No

Oral/throat history

Recurrent infections/sore throats	☐ Yes	☐ No
Strep swab positive?	☐ Yes	☐ No
How many positive test?	_____	
Snoring	☐ Yes	☐ No
Episodes of paused breathing during sleep	☐ Yes	☐ No
If yes, what is the duration?	_____	
Restless sleeper	☐ Yes	☐ No
Difficulty swallowing food	☐ Yes	☐ No
Choking/gagging while eating	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No

Nasal/sinus history

Congestion	☐ Yes	☐ No
Nasal drainage	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
If yes, more often during: ☐ Day ☐ Night		
Headaches	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Allergy testing	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
If yes, how frequent?	_____	

Airway history

Reactive airway disease/asthma	☐ Yes	☐ No
Describe symptoms: _____		
Is it improving with time?	☐ Yes	☐ No
Is it worse with feeding?	☐ Yes	☐ No
Is child gaining weight?	☐ Yes	☐ No
Previous chest x-ray	☐ Yes	☐ No
Previous swallow study	☐ Yes	☐ No
Hospitalization(s) related to airway concerns	☐ Yes	☐ No
ER visit(s) related to airway concerns	☐ Yes	☐ No

IOWA ENT CENTER PLLC

PEDIATRIC HISTORY & PHYSICAL

Past medical history

Gastrointestinal problems

Fevers/chills/weight loss	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Neurological problems		
Balance issues	☐ Yes	☐ No
Head injury	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Heart/cardiac problems	☐ Yes	☐ No
History of bleeding disorder	☐ Yes	☐ No

Any other past medical history or medical diagnosis?: _____

_____

Immune/endocrine problems

Abnormal immune studies	☐ Yes	☐ No
Sweat chloride test	☐ Yes	☐ No
HIV/HEP/TB	☐ Yes	☐ No
Family history of immune disorders	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Genetic diagnosis ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Social history

Adopted	☐ Yes	☐ No
Foster care	☐ Yes	☐ No
Secondhand smoke exposure	☐ Yes	☐ No
Attends daycare	☐ Yes	☐ No
In-home or center?	_____	
Breast-fed or bottle-fed as infant	_____	
How long?	_____	
Grade level in school	_____	

Family history

Life-threatening problems with anesthesia	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Family history of seasonal allergies	☐ Yes	☐ No

If yes, please explain: _____

_____

Genetic disorders	☐ Yes	☐ No
History of early onset hearing loss	☐ Yes	☐ No
Malignant hyperthermia	☐ Yes	☐ No

Other specialty physicians your child sees (please list physician name and their speciality):

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Thank you for taking the time to complete this information for your child.

This is a confidential record of their 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.

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