



PEDIATRIC REGISTRATION FORM (PLEASE PRINT)

PEDIATRIC REGISTRATION				
PATIENT'S FULL NAME:			DATE OF BIRTH:	AGE: <input type="checkbox"/> M <input type="checkbox"/> F RACE:
STREET ADDRESS:			SOCIAL SECURITY:	
CITY:		STATE:	ZIP CODE:	CELL:
FATHER'S NAME:		SOCIAL SECURITY:		BUSINESS/CELL PHONE:
FATHER'S PLACE OF EMPLOYMENT:		WORK ADDRESS:		JOB TITLE:
MOTHER'S NAME:		SOCIAL SECURITY:		BUSINESS/CELL:
MOTHER'S PLACE OF EMPLOYMENT:		WORK ADDRESS:		JOB TITLE:
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:				PHONE:
REFERRED TO CLINIC BY:				
INSURANCE INFORMATION				
PRIMARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SECURITY:			GROUP#/ TRICARE SPONSOR D.O.B
INSURED'S NAME:		PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
PRIMARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SECURITY:			GROUP#/ TRICARE SPONSOR D.O.B
INSURED'S NAME:		PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN				
I GIVE MY PERMISSION FOR THE PHYSICIANS @ ONSLOW EAR, NOSE AND THROAT TO PROVIDE ANY NECESSARY MEDICAL CARE TO MY MINOR CHILD WHOSE NAME IS:				
NAME OF LEGAL PARENT/GUARDIAN:		PARENT/GUARDIAN SIGNATURE:		
REQUIRED SIGNATURE				

I have been provided with the following documents from Onslow Ear, Nose and Throat: Your Rights and Responsibilities as a patient, Notice of Privacy Practice. These documents are also available online at the practice's website (www.onslowent.org)

I authorize the release of information concerning my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for the insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, INC. (for Medicare beneficiaries, this serves as a life time authorization assigning payment of Medicare benefits to Onslow Ear, Nose and Throat). I understand that I am personally responsible for all charges not covered by my insurance.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Patient Portal allows you to have access to Lab results, Medical Records and more. If you are interested please provide your EMAIL below:

E-MAIL: _____



Patient Name: _____ Date of Birth: _____ Age: _____

Gender: Male Female Race: _____

Chief Complaint: _____

PHARMACY INFORMATION	Name: _____	Phone: _____
	Address: _____	

Primary Care Provider: _____ Doctor who referred you here: _____

PAST MEDICAL HISTORY

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes, Type I | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nasal Obstruction |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes, Type II | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Cancer (skin, thyroid, etc)
Type: _____ | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tinnitus |

PAST SURGICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Vocal Cord Surgery |
| <input type="checkbox"/> Neck Surgery (thyroid) | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Sinus Surgery/ Nasal Surgery | <input type="checkbox"/> Sleep Apnea Surgery |
| <input type="checkbox"/> Tonsillectomy/ Adenoideectomy | <input type="checkbox"/> Other: _____ |

MEDICATION HISTORY

List of current medication and dosage: _____

DRUG ALLERGIES

- NO KNOWN ALLERGIES YES: please list and include reaction

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	CHILD(REN)
ANESTHESIA PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING/CLOTTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER-LIST TYPE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEARING LOSS/DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISEASE/CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST HOSPITALIZATION:



SOCIAL HISTORY		
<p>Pediatric exposed to smoke? (Cigarette/Vape) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does patient smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Alcohol usage during pregnancy</p> <p><input type="checkbox"/> Drug usage during pregnancy</p>	<p><input type="checkbox"/> Daycare/Preschool</p> <p><input type="checkbox"/> Grade in School: _____</p>	<p>Other</p> <p><input type="checkbox"/> Loss of School Time in Past Year How Much? _____</p> <p><input type="checkbox"/> Pacifier Use</p> <p><input type="checkbox"/> Siblings How Many? _____</p>

REVIEW OF SYSTEMS

Please check all symptoms which you have presently or have had recently.

CONSTITUTIONAL SYMPTOMS	NEUROLOGIC SYMPTOMS
<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Speech Difficulties <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> weakness <input type="checkbox"/> Other: _____
EAR SYMPTOMS	NOSE SYMPTOMS
<input type="checkbox"/> Earache <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Injury to ear <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Ear Drainage <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Other: _____	<input type="checkbox"/> Stuffiness/blockage <input type="checkbox"/> Postnasal drip/Runny nose <input type="checkbox"/> Nose Bleed <input type="checkbox"/> Snoring <input type="checkbox"/> Loss of smell <input type="checkbox"/> Sneezing <input type="checkbox"/> Other: _____
THROAT/ NECK SYMPTOMS	GASTROINTESTINAL SYMPTOMS
<input type="checkbox"/> Sore Throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Bad breath	<input type="checkbox"/> Heartburn <input type="checkbox"/> Reflux <input type="checkbox"/> Choking on liquids <input type="checkbox"/> Other: _____
ENDOCRINE SYMPTOMS	
<input type="checkbox"/> History of Thyroid problems <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight gain	



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note if you wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information such as test results (including HIV/AIDS), pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time.

Patient Name: _____ Date of Birth: _____

DO NOT release information about: _____

Authorized contact name: _____

Relationship to patient: _____

Contact number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact number: _____

Signature: _____ Date Signed: _____

PHONE RELEASE

I authorize Onslow Ear, Nose, and Throat to leave a message with anyone that answers my phone or on my answering machine in regards to any upcoming appointments, or issues in regards to my care.

Signature: _____ Date Signed: _____



PATIENT/INSURED AGREEMENT

In an effort to provide clear communication with our patients, please be advised as follows:

- The contractual agreement for your medical benefits is between you and the insurance company. We provide billing as a courtesy.
- For all insurance companies that we have a contractual agreement with, we will accept the “In-Network” benefits as outlined on the individual Explanation of Benefits. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all insurance companies that we DO NOT have a contractual agreement with, we will accept the “Out of Network” benefits, if such benefits are available. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all non-contracted insurance companies, you (the patient/insured) will be responsible for all charges incurred in accordance with Onslow Ear Nose and Throat “Private Pay” fee schedule.
- When insurance benefits have been exhausted and/or terminated, you (the patient/insured) will be responsible for the charges incurred in accordance with Onslow Ear Nose and Throat “Private Pay” fee schedule.
- We cannot verify if all services/modalities will be covered by a particular benefit plan. ***THIS IS YOUR (THE PATIENT/INSURED) RESPONSIBILITY!***
- In all cases, you will be responsible for any non covered services, deductibles, co-pays and coinsurance amounts deemed as patient responsibility by your insurance company.

THIS AGREEMENT SUPERSEDES ALL OTHER VERBAL AGREEMENTS.

I have read and agree to be financially responsible for all services both COVERED and NON COVERED by my insurance company.

SIGNATURE

DATE



Pre-Authorization for Medical Care to Children

In the event that you are unable to accompany your minor child to an office visit please provide the name(s) of the individual(s) eligible to authorize care for your child.

<u>NAME</u>	<u>PHONE #</u>	<u>RELATIONSHIP TO CHILD</u>

Please review the following authorization for treatment and complete the information if you wish to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Onslow Ear, Nose and Throat and it's personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT:

Today's Date: _____

Child's Name: _____ Child's Date of Birth: _____

Parent/Guardian Name: _____

Relationship to child: _____

Telephone Number: Home: _____ Cell: _____

Signature of Parent/Guardian: _____



No Show/ Cancellation Policy

Due to the number of patients requesting specific appointment times at Onslow Ear, Nose and Throat our No Show/ Cancellation Policy is:

You will be charged a \$25.00 No Show/ Cancellation fee IF:

- You do not call to cancel **24 hours** prior to your appointment
- You do not check in at front desk before your appointment time (you should plan to be here 15 minutes before you appointment time to complete paperwork)
- You may call our office at (910) 219-3377 and leave a message to cancel your appointment. Our answering service will place a time stamp on your message.
- Having THREE (3) No Shows within a six month period, beginning from the date of the first No Show **may prevent you from being able to schedule further appointments.**

Our main goal is to provide excellent patient care and customer service so we thank you for your understanding in this matter.

Signature

Date

Witness

Date

Patient has refused to sign _____

Patient understands that regardless of signature they will be charged a \$25.00 No Show / Cancellation fee through MED BILL.

Onslow ENT Office Staff