



## REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION			
PATIENT'S FULL NAME:	DATE OF BIRTH:	AGE:	SEX: <input type="radio"/> M <input type="radio"/> F RACE:
STREET ADDRESS:		SOCIAL SECURITY NUMBER	
CITY:	STATE:	ZIP CODE:	
PLACE OF WORK:	WORK ADDRESS:	JOB TITLE:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	
NAME OF PERSON NOT LIVING WITH YOU TO CONTACT FOR EMERGENCY:		PHONE:	
REFERRED TO CLINIC BY:			
INSURANCE INFORMATION			
PRIMARY INSURANCE CARRIER NAME:	POLICY ID /TRICARE SPONSOR SOCIAL SEC. #:		GROUP#/TRICARE SPONSOR D.O.B
INSURED'S NAME:		PATIENTS RELATION TO SUBSCRIBER: <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> CHILD <input type="radio"/> OTHER	
SECONDARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SEC. #:		GROUP#/TRICARE SPONSOR D.O.B:
INSURED'S NAME:		PATIENT'S RELATION TO SUBSCRIBER: <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> CHILD <input type="radio"/> OTHER	
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 Practices. These documents are also available online at the practice's website. ([www.onslowent.org](http://www.onslowent.org))

I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for 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 lifetime 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.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Portal allows you to have access to Appointments, Lab results, Medication refill, 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: \_\_\_\_\_

<b>PHARMACY INFORMATION</b>	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:



<b>SOCIAL HISTORY</b>		
<b>Alcohol Usage</b>	<b>Tobacco Usage</b>	<b>Other</b>
<input type="checkbox"/> Currently Every Day Amount: _____ Type: _____	<input type="checkbox"/> Currently Every Day Amount: _____ Type: _____	<input type="checkbox"/> Prior or Current Recreational Drug Use
<input type="checkbox"/> Currently Some Days <input type="checkbox"/> Former Age Quit: _____ <input type="checkbox"/> Never	<input type="checkbox"/> Currently Some Days <input type="checkbox"/> Former Age Quit: _____ <input type="checkbox"/> Never	<input type="checkbox"/> Other Risk Factors for HIV Explain: _____
		<input type="checkbox"/> Occupation: _____

#### **REVIEW OF SYSTEMS**

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

<b>CONSTITUTIONAL SYMPTOMS</b>		<b>NEUROLOGIC SYMPTOMS</b>
<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Other: _____	<input type="checkbox"/> Difficulty Sleeping	<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: _____
<b>EAR SYMPTOMS</b>		<b>NOSE SYMPTOMS</b>
<input type="checkbox"/> Earache <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Injury to ear <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Ear Drainage <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> right <input type="checkbox"/> left	<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: _____
<b>THROAT/ NECK SYMPTOMS</b>		<b>GASTROINTESTINAL SYMPTOMS</b>
<input type="checkbox"/> Sore Throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bad breath	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Heartburn <input type="checkbox"/> Reflux <input type="checkbox"/> Choking on liquids <input type="checkbox"/> Other: _____
<b>ENDOCRINE SYMPTOMS</b>		
<input type="checkbox"/> History of Thyroid problems <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight gain		



## 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 in accordance with Onslow Ear Nose & 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 & 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'S) RESPONSIBILITY!***
- In all cases, you (the patient/insured) 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



## ACKNOWLEDGEMENT OF RECEIPT OF ONSLOW AMBULATORY SERVICES, INC.

### NOTICE OF PRIVACY PRACTICES

I acknowledge that I was made aware of the Notice of Privacy Practices of Onslow Ambulatory Services (Including, but not limited to, Central Coast Dermatology, Jacksonville Internal Medicine, Onslow Primary Care & Sports Medicine, and Onslow ENT) (Here in after referred to as OAS) on \_\_\_\_\_ (date). I understand that the Notice describes the uses and disclosures of my protected health information by Onslow Ambulatory Services and informs me of my rights with respect to my protected health information.

For more information, please contact the Onslow Ambulatory Service's HIPAA Privacy Officer @ 910-577-2852

Patients address: \_\_\_\_\_

Signature of Patient/Personal Rep.: \_\_\_\_\_

Printed Name Of Patient/Personal Rep.: \_\_\_\_\_

Date: \_\_\_\_\_

Patient refuses to sign or patient deferred signing until further review.

Hospital Representative Initials: \_\_\_\_\_



## 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