COASTAL CAROLINA ENT

REGISTRATION FORM

(Please Print Clearly)

Today's Date: _____/_____/______

Patient Information

Last Name: ____________________________ First Name: _________________________

Social Security Number: ______________________

Street Address: ____

City: __________________________ State: __________ Zip:________________

Home Phone: (_____) ______-___________ Cell Phone: (_____) ______-____________

Gender: ___ Male ___ Female Marital Status:_____________________

Date of Birth: ________________________ Email: _____________________________

Financially Responsible: (if other than patient)

Last Name: ____________________________ First Name: __________________________

Mailing Address: ____

Date of Birth: ________________________ SS#: _______________________________

Relationship to Patient: ________________________

Please Read & Sign Below:

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits to be made directly to Coastal Carolina ENT. Any unexpected balance left after insurance payment has been received will be due to in full within 90 days of notification from this office. I further understand that any sums due to me, if less than $100.00 will be credited to my medical account. This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

I have read and understood all of the above and have given truthful information to the best of my knowledge:

Signature: __________________________________ Date: _________________________

COASTAL CAROLINA ENT

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form to the best of your knowledge. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into our computer and you are welcome to a copy of the report if you wish.

Full Name: ____ DOB:___/___/_____

Pharmacy Preference (include location): ____

Name & Location of Primary Care Doctor: ____

Current Height: ____________ Current Weight: _____________

Current Medication (this includes prescription, over the counter or herbal medications):

Medication Name	**Dosage**	**How often taken**

Are you allergic to any medications? Yes____ No____ If yes, please list the names of the medications: ____

Have you had any previous surgery or procedures: Yes____ No ____ If yes, please list below.

Type of surgery or procedure	**Date**

What is the reason for your visit today? ____

How long have you been experiencing this problem? ________________________________

Did another physician refer you to us? (is so please tell us who) ________________________

____ ________________

Patient Signature **Date**

Designation of Care Givers for Communication of Protected Health Information

Patient Name: ______________________________ Current Date: ___/____/____

Chart #: __________ Date of Birth: ___/___/_____

At my request, I authorize the person(s) below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this person(s) may inquire about the child's personal health and/or billing information and, if necessary, bring the child to appointments on my behalf.

Name	Relationship	DOB	Phone Number

OR

_____ (initial) I do not want my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize Coastal Carolina ENT to communicate my protected health information to me via the following methods: (check all that apply)

___ Leave detailed message on my home answering machine: Phone # __________________

___ Leave message with call-back number only.

___ Leave detailed message on my voice mail at work: Phone # ________________

___ Leave detailed message on my cell phone voice mail: Phone # ________________

___ Fax detailed medical information: Fax # ________________

____ ________________

Authorized Patient or Guarantor Signature Date

____

Print Name