**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\* Statements will be sent by E-Mail. If you prefer it be sent by USPS, please check here. \_\_**

**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 This authorization is valid unless rescinded in writing.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**

|  |  |  |
| --- | --- | --- |
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|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are you allergic to any medications? Yes\_\_\_\_ No\_\_\_\_ If yes, please list the names of the medications & reactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? (if 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

**COASTAL CAROLINA ENT, DO, PA**

*Otolaryngology ~ Head and Neck Surgery ~ Facial Plastic and Cosmetic Surgery ~ Allergy*

302 Liberty Street 2298 Ocean Hwy W. 3806 Sawtell Road

Whiteville, NC 28472 Supply, NC 28462 Little River, SC 29566

(*910) 914-0540 (P) (910) 755-3682 (P) (843) 663-9090 (P)*

*(910) 914-0640 (F) (910) 755-6923 (F) (843) 663-9091 (F)*

**DIAGNOSTIC SCOPE/PROCEDURE**

If you are here for a sinus or throat issue, the doctor may need to perform in diagnostic, scope/procedure.

This is to inform you that there will be an additional charge sent to your insurance company for this. Some insurance companies will bill this as a “surgery” and this charge may go towards your deductible.

I agree to have this scope/procedure done and I will be responsible for any bills that may occur in relation to this.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**VACCINATIONS**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Information:**

Please indicate if you had the following screenings and/or vaccines, and when the last one was done.

 YES NO WHEN/LAST

Breast Cancer Screening (Mammogram) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Cervical Cancer Screening (Pap Smear) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Colorectal Cancer Screening (Colonoscopy) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Pneumococcal Vaccine (Pheumonia Vaccine) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Prevnar (PCV) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Influenza (Flu Vaccine) \_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_