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 This authorization is valid unless rescinded in writing.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**

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
Whiteville, NC 28472
(910) 914-0540 (P)
(910) 914-0640 (F)

2298 Ocean Hwy W.
Supply, NC 28462
(910) 755-3682 (P)
(910) 755-6923 (F)

3806 Sawtell Road
Little River, SC 29566
(843) 663-9090 (P)
(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)	____	___	____________