PROVIDENCE Health & Services

Patient Registration Form Date: ____/____/____ Time: _____

Patient Information

Patient Name:		Soc Sec #:
Sex:	Birth Date:	Aliases:
Street Address:		Home Phone: Work Phone:
City:		Mobile:
State:	ZIP:	Comments:
Email:		
Interpreter Needed: □ Yes □ No	Language:	Ethnicity: □ Hispanic □ Non-Hispanic
Marital Status: □ Mar □ Sing □ Wid □ Div □ Sep		Race:
□ Deaf or Hard of Hearing □ Blind or Vision Impaired Needs: □ Sign Interp □ Tactile Interp Other:		

Primary Care Provider Information

PCP:	Phone:	Group:

Emergency Contact

Contact Name:		
Street Address:		Home Phone: Work Phone:
City:		Mobile:
State:	ZIP:	Comments:
Email:		
Relationship to Patient:		Legal Guardian? □ Yes □ No

Patient's Employer

Employer:		Status: □ Full Time □ Part Time □ Retired □ Disabled □ FT Student □ PT Student □ Not Employed □ Never Employed □ On Active Military Duty
Work Address:		
City:	Employment Date:	Employee ID:
ZIP:	Phone:	Occupation:

PROVIDENCE
Health & Services

Guarantor Information ☐ **Same as patient**			
Guarantor Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Street Address:		City:	Home Phone:
		ZIP:	Work Phone:
Relationship to Patient:			

Guarantor Employment		
Employer:		Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ FT Student ☐ PT Student ☐ Not Employed ☐ Never Employed ☐ On Active Military Duty
Work Address:		
City:	Employment Date:	Employee ID:
ZIP:	Work Phone:	Occupation:

Primary Insurance Info ☐ **Same as patient** ☐ **Same as guarantor** ☐ **Provided to Reception**			
Subscriber Name:			Soc Sec #:
Sex:	Birth Date	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City:
			ZIP:
Primary Insurance Company & Plan			

Secondary Insurance Info ☐ **Same as patient** ☐ **Same as guarantor** ☐ **Same as primary**			
Subscriber Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City:
			ZIP:
Secondary Insurance Company & Plan:			

Thank you for helping us keep all your important information current!

PROVIDENCE Health & Services

Patient Label

PACIFIC HEAD & NECK SM

NEW PATIENT HISTORY FORM

PATIENTS NAME: _____ DATE: _____

How did you hear about us? _____

HEIGHT: _____'_____" WEIGHT: _____lbs.

Chief Complaint: What is the reason for this appointment? _____

_____

Allergies: See MyChart ☐ _____

_____

Medications: See MyChart ☐ _____

_____

Medical Conditions/ History: See MyChart ☐

_____

_____

Surgical History: See MyChart ☐ _____

_____

Family History: See MyChart ☐ _____

_____

Social History

Do you smoke/chew tobacco? _____ How much? _____

Do you drink alcohol? _____ How much? _____

REVIEW OF SYSTEMS (check any that apply):

EARS:	☐ Hearing Aids ☐ Exposure to Loud Noise	☐ Pain ☐ Tinnitus (noise in ears)	☐ Dizziness/Vertigo ☐ Discharge	☐ Surgery:_____ ☐ Other:_____
NOSE :	☐ Difficulty Breathing ☐ Snoring	☐ Stuffiness ☐ Nasal Sprays	☐ Bleeding ☐ Injuries	☐ Change in Smell ☐ Post Nasal Drip ☐ Surgery:_____
THROAT:	☐ Soreness ☐ Bad Taste ☐ Throat Clearing	☐ Pain or Difficulty Swallowing ☐ Recent Dental Work ☐ Voice Change/Hoarseness	☐ Tonsillitis ☐ Bad Breath ☐ Lump	☐ Cough ☐ Reflux ☐ Surgery:_____
NECK:	☐ Lumps ☐ Pain	☐ Thyroid Nodules ☐ Swollen Glands	☐ Injuries ☐ Surgery:_____	
EYES:	☐ Loss/Blurred Vision ☐ Crossed Eyes ☐ Lazy Eye ☐ Eye Disease	☐ Double Vision ☐ Itching, Burning, Irritation ☐ Floating Objects in Vision ☐ Cataracts	☐ Injuries ☐ Pain/Soreness ☐ Dryness of Eyes ☐ Light Sensitivity	☐ Excess Tearing ☐ Redness/Inflammation ☐ Glaucoma ☐ Surgery:_____
OTHER:	☐ Easy Bleeding ☐ Fever ☐ Chest Pain ☐ Cough	☐ Seizures ☐ Rash ☐ Prostate Problems ☐ Kidney Disease	☐ Heartburn ☐ Arthritis ☐ Depression ☐ Anxiety	☐ Surgery:_____ ☐ Other: _____

PACIFIC HEAD & NECK℠

FINANCIAL ACKNOWLEDGEMENT

PACIFIC NEUROSCIENCE INSTITUTE®

Please initial the following:

_____**REFERRALS:** If you have an HMO, or similar plan (EPO), you will need a referral from your primary care physician to see our specialists. Any additional procedures performed will require authorization from your insurance. If we have not received a referral prior to your arrival at our office, your appointment may need to be rescheduled. It is YOUR responsibility to know if a referral is required and to obtain one.

_____**INSURANCE BENEFITS:** It is the patient's responsibility to know their insurance benefits and to know the in-network and out-of-network status for our providers; this can be checked by calling the insurance company. Please be aware that when a patient requires a visit to a specialist, there are procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures/surgeries. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Depending on the insurance coverage these procedures may apply toward your insurance deductible. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Nasal Hemorrhage Control	Cerumen (ear wax) Removal
Foreign Body Removal	Tympanostomy/Myringotomy
Labs/Cultures/Pathology	Flexible/Rigid Stroboscopy
Nasal Endoscopy with/without Debridement	Flexible/Rigid Laryngoscopy

_____**FORM FEES:** Any forms (i.e. FMLA, Short-term disability, other extended leave of absences, etc.) which require our physicians to complete, must be given to our office staff in a timely manner and may require a fee before being completed. Please allow 10 business days for completion.

_____**MEDICAL/BILLING RECORDS FEE:** Any request for medical or billing records must be accompanied by an authorization for release of information (obtainable from the front desk or back office staff). We will make every effort to provide your records via copies or electronically, within 10 business days, so please make your request well in advance of other physician appointments. There may be fee for extensive medical records.

_____**FINANCIAL RESPONSIBILITY:** I have read this notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these procedures will be billed to my insurance, if any. I understand there are other procedures which may be performed as part of my diagnosis or treatment that may not be listed above. I will be responsible for any amount not covered by my insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify Pacific Neuroscience of any changes in my insurance coverage. I understand by signing this form I am accepting full financial responsibility as explained above for all payment for services rendered.

Signature:

Printed Name: _____

Relationship to patient, if different:

Witness Name & Signature: _____

Date: _____