THE CENTER FOR ENT
Sinus + Allergy + Hearing

Patient Registration Form

Patient Information					
Last name, First name, MI			Referring Physician:	Marital Status: ☐Single ☐Mar ☐Div ☐Sep ☐Wid	
DOB:	Age:	Drivers Lic.#:	Primary Language:	Gender:	Race:
Address:			City:	State:	Zip Code:
Home phone:	Mobile Phone:		Email:		
Employer:			Phone:	Fax:	
Address:			City:	State:	Zip Code:
Emergency Contact:			Phone:	Relation:	
Primary Care Physician:			Phone:	Fax:	
Other Contacts: (List other people who we may inform about your health information)					

Primary Insurance		Secondary Insurance	
Primary Insurance:		Secondary Insurance:	
Subscriber Name:	DOB:	Subscriber Name:	DOB:
Policy #:	Group #:	Policy #:	Group #:
Employer:		Employer:	

Medical History

Last name, First name, MI			Date:
Reason for appointment:	Height:	Weight:	Pregnant? ☐No ☐Yes Breastfeeding? ☐No ☐Yes
Current Medications:			
Medication Allergies? ☐No ☐Yes (list medication and reaction)			
Pharmacy Name/Location:	Phone:		Fax:

Medical History

☐ Sinusitis	☐ Bleeding Disorder	☐ Gastric Reflux (GERD)	☐ Stroke
☐ Allergy/Asthma	☐ Cancer	☐ Heart Disease	☐ Thyroid Disorder
☐ Hearing Loss	☐ Diabetes	☐ Hypertension	☐ Other

Explanation:

Surgeries (include year)

Family History (Serious Illnesses)

Mother:	Sibling:
Father:	Child:

Social History

Occupation:	Tobacco Use: ☐No ☐Yes ____packs/day ____years	Alcohol Use: ☐No ☐Yes _____drinks/week

Currently, which symptoms do you have?		☐ skin rash	☐ sinus congestion	☐ muscle/joint pain
☐ seasonal allergies	☐ shortness of breath	☐ sensitivity to cold	☐ heartburn	☐ headache
☐ cough	☐ fever	☐ hearing loss	☐ bruise easily	☐ blurred vision