

New Mexico Ear, Nose & Throat Specialists, PC
Frederick Fiber, MD **Dorothy McCurley, AuD**

Patient Registration

Date _____

Name _____ Birthdate _____ Age _____ Sex M / F

Social Security # _____ Marital Status S M W D Sep

Address _____
Street Apt. # City State Zip

Patient's Employer _____ Occupation _____

Employer Address _____ Telephone # _____

Parent/Spouse Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Telephone # _____

Referring Doctor _____ **Phone #** _____

Primary Doctor _____ **Phone#** _____

Preferred Pharmacy _____ **Pharmacy Tel #** _____

If you were not referred by your doctor, how did you learn about our office? _____

How to contact you:

We take your privacy very seriously. If the physician(s) or staff need to contact you regarding your care, additional appointments or surgery information, we ask that you identify the best way to contact you.

- Home Phone _____
- OK to leave detailed message.
- Leave general message with call back number only.
- Cell Phone _____
- OK to leave detailed message.
- Leave general message with call back number only.
- Work Phone _____
- OK to leave detailed message.
- Leave general message with call back number only.
- Fax
- OK to fax to this number _____

If we are unable to speak directly with you, please list spouse, family members or friends with whom we can speak regarding your appointments, surgical dates, or other personal health information.

Name _____ Telephone # _____
Relationship _____

Name _____ Telephone # _____
Relationship _____

Name _____ Telephone # _____
Relationship _____

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Whom should we contact in the event of an emergency?

Name _____ Telephone # _____
Relationship _____

Insurance Information

Primary Insurance _____ Telephone _____

Claim Address _____

Policy # _____ Group # _____ ID # _____

Name of Insured _____ Relationship _____ DOB _____

Secondary Insurance _____ Telephone _____

Claim Address _____

Policy # _____ Group # _____ ID # _____

Name of Insured _____ Relationship _____ DOB _____

Have you been referred under Worker's Compensation? Y / N

Date of Injury _____ Claim Number _____

Insurance Company _____

Adjustor Name _____ Telephone # _____

The information indicated on this form is true and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process my insurance claim(s). I hereby authorize payment directly to the NMENTS for services rendered on my behalf. I further authorize the release of medical records to my referring physician, worker's compensation carrier (if applicable) and /or any other physicians or medical services to which this office refers me.

I have received a copy of the NMENTS Financial Policy. I understand that I am personally responsible to NMENTS for any unpaid balance and I agree to pay such balance in full.

I understand that a \$50 fee will be applied to my account if I cancel or reschedule an appointment with less than 24 hours advanced notice. I understand that a \$100 fee will be applied to my account if I fail to cancel or reschedule surgery with less than 48 hours notice. I understand that this fee is not billable to my insurance and appointments may not be rescheduled until this fee is paid in full.

I received a copy of the NMENTS Privacy Policy. If I have given permission to leave detailed messages, fax information regarding my care, and/or discuss my medical care with specific family and/or friends, I understand that I am granting a waiver to NMENTS of my privacy rights under HIPAA. If I decide to change these instructions, I will notify NMENTS in writing as soon as possible.

Patient/Parent Signature _____ Date _____

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Registration for a Minor

****A minor is a young person under the age of 18 years.**

Patient Name _____ Birthdate _____

It is legally necessary for this office to have written consent for the medical treatment of any minor from a proper adult. Consent for treatment can be given **ONLY** by a natural or adoptive parent, an adult with legal custody of the minor, or a legally appointed guardian. For this reason, please identify your relationship to the minor patient and the legal basis for your authorization of treatment.. Please check the status that applies:

I am the _____ biological / adoptive parent _____ legal custodian
_____ court-appointed guardian of the minor seeking medical treatment.

Minor child resides with _____ biological / adoptive parents
_____ biological / adoptive mother
_____ biological / adoptive father
_____ Legal Custodian
_____ Court-appointed Guardian

The information indicated on this form is true and accurate to the best of my knowledge.

Signature _____ Relation to child _____ Date

NOTE to Legal Custodians and Legal Guardians: You may be asked to provide proof of your status. Please bring a copy of your legal documents to the office at the time of the child's visit.

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Medical History

Name _____ Date _____

Birthdate _____ Age _____ M / F _____ Social Security # _____

Referring Physician _____

What medical problem brings you to the office today? _____

List **prescription medications** you are currently taking: _____

List **over the counter medications and herbal remedies** you are currently taking: _____

List any known **drug** allergies and reaction: _____

List other allergies (hay fever, foods, etc.): _____

List any surgeries or hospitalizations with reason and date: _____

Occupation _____

Do you smoke? ___ yes ___ no How much per day? _____ for # Years _____

Do you drink: Caffeinated beverages? ___ yes ___ no Alcohol? ___ yes ___ no Amount: _____

Height _____ Weight _____

Do you currently have or have you had any of the following? Please circle answer and describe if YES.

	PATIENT	DESCRIPTION	FAMILY
GENERAL: (Chronic fever, unexpected weight loss/gain, fatigue, other)	NO YES	_____ _____	YES
NEUROLOGICAL: (Headaches, head injury, seizures, stroke, other)	NO YES	_____ _____	YES
EYES: (Glaucoma, cataracts, detached retina, other)	NO YES	_____ _____	YES
EARS: (Chronic infections, hearing loss, Menieres disease, ear surgery, other)	NO YES	_____ _____	YES

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	PATIENT		DESCRIPTION	FAMILY
NOSE: (Bleeding, chronic sinusitis, broken nose, obstruction, other)	NO	YES	_____	YES
MOUTH: (Mouth sores, lumps, tonsillitis, dental problems, other)	NO	YES	_____	YES
THROAT: (Hoarseness, acid reflux, voice change, swallowing problem)	NO	YES	_____	YES
NECK: (Lumps, swollen glands, other)	NO	YES	_____	YES
SKIN: (Growths, rash, psoriasis, itching)	NO	YES	_____	YES
HEART: (Irregular beats, heart attack, pacemaker, chest pain, murmur, other)	NO	YES	_____	YES
LUNGS: (Asthma, emphysema, cough, wheezing, TB, shortness of breath, other)	NO	YES	_____	YES
GASTROINTESTINAL: (Heartburn, ulcers, reflux, rectal bleeding, diarrhea)	NO	YES	_____	YES
GENITOURINARY: (pain, blood in urine, infections, prostate problems, menopause)	NO	YES	_____	YES
MUSCLE/JOINTS: (Back, joint pain, arthritis, lupus, gout, other)	NO	YES	_____	YES
BLEEDING DISORDER: (anemia, transfusions, bruise/bleed easily, other)	NO	YES	_____	YES
PSYCHIATRIC: (Severe depression, bipolar disorder, other)	NO	YES	_____	YES
ENDOCRINE: (Diabetes, thyroid disease glandular/hormonal problem)	NO	YES	_____	YES
INFECTIOUS DISEASES: (HIV, Hepatitis B, C, herpes, other)	NO	YES	_____	YES

CANCER: If yes, please describe _____

Name of physician(s) you see for any of the above _____

If this form is completed by anyone other than the patient, please write name and relationship to patient.

Name: _____ Relationship: _____

I certify that this information is true and correct to the best of my knowledge.

Signature _____ Date _____

I have reviewed the above information with the patient. _____ MD