

New Mexico Ear, Nose & Throat Specialists, PC

Frederick Fiber, MD

Dorothy McCurley, AuD

Patient Registration Update

Name _____ DOB: _____ Marital Status S M W D Sep

Address _____
Street Apt. # City State Zip

Referring Doctor _____ Primary Doctor _____

Preferred Pharmacy _____ Pharmacy Telephone# _____

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 _____

How to contact you: We take your privacy very seriously. If the physician(s) or staff need to contact you regarding your care, 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 & call back number only.

Cell Phone _____

OK to leave detailed message
 Leave general message & call back number only.

Work Phone _____

OK to leave detailed message.
 Leave general message & call back number only.

Fax Number _____

OK to fax to the number above.

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 _____

Whom should we contact in the event of an emergency?

Name _____ Telephone # _____
Relationship _____

The information indicated on this form is true and accurate to the best of my knowledge. I have received a copy of the NMENTS Financial and Privacy Policies. I understand 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 fail to cancel or reschedule an appointment with a minimum of 24 hours advanced notice. I understand that a fee of \$100 will be applied to my account if I fail to cancel a surgery with a minimum of 48 hours advanced notice.** 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 authorize the release of medical records to my referring physician and /or any other physicians or medical services to which this office refers me. 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 _____

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

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
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EYES: (Glaucoma, cataracts, detached retina, other)	NO	YES	_____	YES
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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,			_____	
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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 Signature