Mid-Valley ENT & Allergy
ENT Hearing & Balance Center

PATIENT REGISTRATION FORM

Today's date: ____ /____ /_____ Email: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ ☐Mr. ☐Mrs. ☐Ms.

Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Language preferred: _____ Ethnicity: _____ Race: _____ Birthdate: ____ /____ /_____ Age: _____ Sex: ☐M ☐F

Street address: _____ Social security no.: _____ Phone: _____

P.O. box: _____ City: _____ State: _____ ZIP code: _____

Doctor who referred you: _____ Primary doctor: _____

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Primary insurance: _____ Policy #: _____ Group #: _____

Secondary insurance: _____ Policy #: _____ Group #: _____

PHARMACY INFORMATION

Name of primary pharmacy: _____ City: _____ State: _____

PARENT/GUARDIAN INFORMATION

Responsible party: _____ Relationship to patient: _____

Home phone: _____ Work phone: _____

Street address: _____ Social security: _____ Birthdate: ____ /____ /_____

P.O. box: _____ City: _____ State: _____ ZIP code: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: _____ ☐ Able to release medical information including labs/paths/imaging

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mid-Valley ENT & Allergy or insurance company to release any information required to process my claims.

AUTHORIZATION FOR RELEASE OF MEDICATION: I authorize Mid-Valley ENT & Allergy to obtain my medication history from my pharmacy and/or referring physician.

_____ ____ /____ /_____

Patient/guardian signature Date

Albany Clinic:
950 29th Ave. SW
Albany, OR 97321
PHONE: 541-967-0404

Newport Clinic:
1010 SW Hwy. 101
Newport, OR 97365
PHONE: 541-967-0331

FAX: 541-967-6548
midvalleyentallergyandhearing.com

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PATIENT MEDICAL HISTORY & PHYSICAL FORM

Name: _____ DOB: _____ ☐Male ☐Female Referred by: _____

Reason for Visit: _____ Height: _____ Weight: _____

Do you experience any hearing loss? ☐Yes ☐No

Do you experience any dizziness? ☐Yes ☐No Do you experience ringing or noise in your ears? ☐Yes ☐No

EAR			NOSE			ORAL/THROAT		
Dizziness	☐Y	☐N	Nasal Drainage	☐Y	☐N	Hoarseness	☐Y	☐N
Decreased Hearing	☐Y	☐N	Nasal Obstruction	☐Y	☐N	Difficulty Swallowing	☐Y	☐N
Ear Pain/Pressure	☐Y	☐N	Decreased Sense of Smell	☐Y	☐N	Dry Mouth	☐Y	☐N
Ear Drainage	☐Y	☐N	Nasal Bleeding	☐Y	☐N	Throat Pain	☐Y	☐N
Ringing	☐Y	☐N	Sinus Pain/Pressure	☐Y	☐N	Snoring/Apnea	☐Y	☐N

List ALL Medical Problems Past and Present

_____
_____
_____
_____
_____

Medications: NONE or LIST ALL

_____
_____
_____
_____
_____

List ALL Past Surgeries

_____
_____
_____

Allergies to Medications: NONE or LIST ALL

_____
_____
_____

Social History/Habits

Tobacco Use: ☐Yes ☐No Cigarettes/Day: _____ Former Smoker: ☐Yes ☐No Years Smoked: _____ Year Quit: _____

Tobacco Use in Other Forms: (please specify) _____

Family History – Please Identify All Medical Issues that BLOOD RELATIVES Have Had Past and Present:

Father: ☐Alive ☐Deceased ☐Unknown
Diabetes: ☐Y ☐N High Blood Pressure: ☐Y ☐N Heart Disease: ☐Y ☐N Mental Illness: ☐Y ☐N Cancer: ☐Y ☐N
Mother: ☐Alive ☐Deceased ☐Unknown
Diabetes: ☐Y ☐N High Blood Pressure: ☐Y ☐N Heart Disease: ☐Y ☐N Mental Illness: ☐Y ☐N Cancer: ☐Y ☐N

Are you CURRENTLY experiencing any of the following (please circle):

General:
Fatigue
Fevers
Night Sweats
Weight Loss

Allergy:
Post Nasal Drip
Runny Nose
Congestion
Itchy Eyes/Nose/Throat

Eyes:
Blurred Vision
Dry Eyes
Itchy/Redness

Respiratory:
Asthma
Cough
Shortness of Breath

Cardiovascular:
Chest Pain
Irregular Heartbeat

Gastrointestinal:
Heartburn/Reflux
Nausea
Vomiting

Hematology:
Bleeding Problems
Easy Bruising
Swollen Glands

Skin:
Eczema
Hives
Skin Cancer
Skin Lesions

Neurologic:
Balance Difficulty
Headache

Have you or a blood relative had either of the following: Anesthesia Problems ☐Y ☐N Bleeding Disorder ☐Y ☐N

_____ _____ _____
Patient Signature Dr. Signature Date

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PATIENT RESPONSIBILITY DISCLAIMER FORM

Patient/Responsible Party Signature _____ Date _____

Thank you for choosing Mid-Valley ENT & Allergy/Hearing & Balance Center as your health care provider. We are committed to providing you with the highest quality health care. We ask that you read and sign to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and up-to-date information regarding their insurance. Please provide BOTH primary insurance and secondary (if applicable) insurance. Some insurance companies only allow 90 days to bill before they deny a claim. If you give us the incorrect information and we are not able to bill before the 90-day period, the patient/responsible party will be responsible for any charges that are incurred.
- Patients are responsible for payment of co-pays, co-insurance and deductibles.
- **Co-pays are due at the time of service.**
- No valid referral/authorization from your primary care physician at the time of visit (some insurance companies require an authorization from your primary care physician or they will deny payment to us).
- Worker's Compensation claim in deferred or denied status.
- **For self-pay patients, payment will be collected at the time of service.**
- Managed care plans and HMO plans. These insurances require authorization before you can be seen by a specialist. It is your responsibility to know whether your insurance plan allows you to be seen by our providers at Mid-Valley ENT & Allergy/Hearing & Balance Center.
- Charges for returned checks.

No-Show Policy: As a courtesy, we agree to confirm your appointment by an automated reminder via email or call to your primary phone number one day before your scheduled appointment. You will, at that time, have the opportunity to cancel or confirm your appointment. **If you need to cancel or reschedule your appointment, we request a 24-hour advanced notice**. Early cancellation will allow us to give another person the possibility to have access to timely medical care. A "no-show" is a cancellation without calling to inform us ahead of time.

- **First no-show:** There will be no charge. We understand that there are circumstances (life happens) that could prevent you from showing up.
- **Second no-show:** A $25 fee will be billed to your account and must be paid prior to your next appointment.
- **Third no-show:** A $50 fee will be billed to your account and must be paid prior to your next appointment.
- **If you are 15 or more minutes late for a HEARING TEST APPOINTMENT, you may be rescheduled.** It is important that these appointments run on time.

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INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:
I hereby authorize a direct payment of my medical benefits to Mid-Valley ENT & Allergy/Hearing & Balance Center on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS
I hereby authorize Mid-Valley ENT & Allergy/Hearing & Balance Center to release to my insurer, governmental agencies or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment of examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

COMMUNICATION AUTHORIZATION
By my signature below, I authorize Mid-Valley ENT & Allergy/Hearing & Balance Center to communicate by mail, answering machine message and/or email according to the information I have provided in my patient registration information.

Signature of Patient/Authorized Representative or Responsibly Party

Date

Printed Name of Patient/Authorized Representative or Responsibly Party

Date

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ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

You May Refuse to Sign This Acknowledgement

I acknowledge that I have been informed of the office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____
(Reason)

_____
(Employee Signature and Date)

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