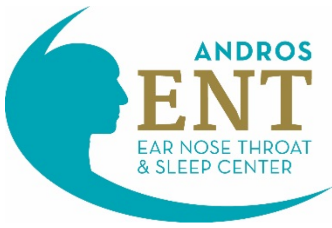


Andros ENT & Sleep Center

ADULT PATIENT REGISTRATION FORM

PLEASE PRINT

Today's Date:	Primary Doctor:

PATIENT INFORMATION

Last Name	First Name	M.I	DOB: / /	Age:	Sex: ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Social Security #:	Email Address:

Street Address:	City:	State:	Zip:

Home #:	Cell #:	Work #:

Employer Name & Address:	Employer Phone Number:

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

Name of Policy Holder:	DOB: / /	Address of Policy Holder:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ______________________

Group Number:	Policy ID Number:

SECONDARY INSURANCE INFORMATION

Name of Policy Holder:	DOB: / /	Address of Policy Holder:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ______________________

Group Number:	Policy ID Number:

EMERGENCY CONTACT

Name:	Relationship:	Phone:

I attest that the above information is true to the best of my knowledge. I authorize Andros ENT & Sleep Center to charge my insurance based on the information I provided for services rendered. I acknowledge that I am responsible for all fees that are not covered by my insurance.

____ Signature

___________________________________ Date

Patient Name:	**Birth Date: ____/____/____**	**Age: ____________**

Primary care physician: ____ Clinic: _____________________________________

Doctor who referred you: ____ Clinic: _____________________________________

Reason for today's visit: ____

May we contact you by email or direct mail with newsletters, updates, advertisements related to Andros ENT?

Yes/No if yes, email address: ____ Initial: __________________

With whom would you like us to share info about your care at Andros ENT? (Please check all that apply)

_____ No one _____ Primary MD _____ Referring MD _____Others: ____

Name: ____

Legal guardian: ____ Date: __________________________________

Power of attorney: ____ Date: __________________________________

History of Present Illness (Please answer as accurate as you can)

Are you on disability because of your problem? Yes/No

When did your problem start? ____

What treatment(s) has been done so far? ____

____

Are your symptoms improving or worsening? ____

____

What makes your symptoms better/worse? ____

____

Past Medical History

(Please list all medical problems such as; high blood pressure, diabetes, cholesterol)

Social History

How often do you drink alcohol? ____# drinks per day/week/other: __________________________

Do you smoke? Yes /No if so, how much/how long? ________________________ Age when you started: ______

Are you employed? Yes /No if so, what is your occupation? ___________________________________

What is your marital status: _______________________________

Do you drink caffeinated beverages? Yes/No if so, how many per day? _______# of cups cans per day week

Do you drink coffee, tea, or soda? __________________________

Do you exercise? Yes/No if so, how often per week? ________________ Do you use any recreational drugs? Yes No

ANDROS ENT
EAR NOSE THROAT & SLEEP CENTER

Please list all surgeries/operations

Type of Surgery	Date of Surgery

Family History (check all that apply)

	Mother	Father	Sister	Brother	Grandmother (m)	Grandfather (m)	Grandmother (f)	Grandfather (f)
Allergy								
Asthma								
Bleeding Disorder								
Cancer: Type								
Diabetes: Type								
Hearing problems								
Heart problems								
Malignant Hyperthermia								
Meniere's								
Migraines								
Narcolepsy								
Restless Legs								
Sleep Apnea								
Thyroid Problems								

Patient Name:

Patient Medication Form

Do you have a preferred pharmacy? ______ Yes ______ No if yes, please list below.

Pharmacy name: ____

Pharmacy phone: _________________________________ Pharmacy fax: _______________________________

Pharmacy address: ____

Please list all medications you are currently taking including over-the-counter medications, herbals, vitamins, etc. Ask for additional sheets if necessary.

Medication Name	Dose/Strength	Reason for taking

Patient Allergy Information

1. Allergic to latex? Yes No
2. Allergic to medical tape? Yes No
3. Have any known drug allergies? Yes No
4. If yes, please list all the medications below. Attach additional sheets as necessary.

Medication patient is allergic to	Reaction

Patient Name:

Review of Systems

Circle any that applies to indicate whether you presently have any of the following symptoms. For any yes responses, please check if current.

Allergy:

Sneezing | Environmental allergy | Post-nasal drip | Food allergies (list): ______________________________

ENT:

Ear pain/itch	Ear drainage	Hearing loss	Ear noises/ringing
Dizziness	Light-headedness	Nasal congestion	Throat pain
Sense of smell	Snoring/apnea	Throat clearing	Vocal loss
Hoarseness	Throat dryness	Throat itching	
Daytime naps	Difficulty swallowing	Sinus pressure/pain	

Respiratory:	Cough	Wheezing	Coughing blood	Shortness of breath
Eyes:	Eye pain	Watery eyes	Itchy eyes	
GI/Gy:	Upset stomach	Heartburn	Bedwetting	Difficulty passing urine
Neurological:	Migraines	Headache	Weakness	Numbness and tingling
General:	Chills	Fatigue	Weight loss/gain	Daytime sleepiness
Endocrine:	Feel warmer than others		Feel cooler than others	
Heme/Lym:	Swollen glands	Bleeding problems	Night sweats	Easy bruising
Cardio:	Chest pain	Palpitations		
Muscular:	Joint aches	Muscle pain	Chronic back pain	
Skin:	Rash	Itching	Hives	Skin changes
Psych:	Depression	Anxiety	Panic attack	

The Center for Medicare/Medicaid Services, the federal agency overseeing government-funded healthcare and its quality, has requested that we collect the following information on all patients seen in our clinic. This information will be used to help improve the quality and effectiveness of care for populations at risk for specific conditions, make available funding for crucial support services such as interpreters, and provide preventive screening for specific populations. The collection of this information is legal under Minnesota state law and is federally covered under Title VI of the Federal Civil Rights Act of 1964. In an effort to provide the best possible care for our patients, please check your race, ethnicity and your preferred language from the list below. This will help us to ensure the highest quality of service for you. **Your answers will be confidential**

Patient Name ___________________________ Date of Birth _____________
(Please print)

Please check the RACE that best describes you:

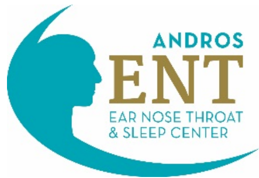
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White or Caucasian
- ☐ Multi-racial
- ☐ Choose not to disclose/ decline

Please check the ETHNICITY that best describes you:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Choose not to disclose/decline

Please check your primary LANGUAGE:

☐ Amharic	☐ Arabic	☐ Bosnian	☐ Burmese	☐ Cambodian
☐ Chinese	☐ English	☐ French	☐ German	☐ Hindi
☐ Hmong	☐ Italian	☐ Japanese	☐ Karen	☐ Korean
☐ Laotian	☐ Mandarin	☐ Oromo	☐ Polish	☐ Romanian
☐ Russian	☐ Sign Language	☐ Somali	☐ Spanish	☐ Swahili
☐ Tagalog	☐ Tibetan	☐ Tigrinya	☐ Urdu	☐ Vietnamese
☐ Yorba	☐ Other	Specify____________		☐ Decline Answer



Name: ______________________________
Date: _______________________________

Bleeding History

PERSONAL HISTORY

Do you bruise easily?	YES	NO	
Do you get bruises larger than 2 inches	YES	NO	
Do you get frequent nosebleeds?	YES	NO	
(Females only) Do you have heavy menstrual periods?	YES	NO	N/A
Have you bled excessively with:			
Surgery	YES	NO	
If yes, what was the procedure? ________________________________			
An accidental cut or injury?	YES	NO	
Dental extractions?	YES	NO	
(Males only) Circumcision?	YES	NO	N/A

Please read this list of medications/herbals and circle any that you take:

Aspirin, ibuprofen (Advil, Motrin) or naproxen (Alves)? YES NO
*If yes, discontinue use **1 week** before surgery

Omega 3 fatty acids, St. John's Wort, cayenne, cumin, garlic, evening primrose oil, ginkgo biloba, ginseng, grape seed extract, milk thistle, turmeric, vitamin C, vitamin E, onion extract, Benadryl, Claritin, Allegra, Zyrtec, or cough and cold medicine YES NO
*If yes, discontinue use **2 weeks** before surgery

FAMILY HISTORY (Answer these questions to the best of your knowledge. If unknown, circle no)

Are you adopted or is your family history unknown? If yes, STOP	YES	NO
Has anyone in your family needed a blood transfusion? If so, why?	YES	NO

____

Has anyone in your family been called a "bleeder"?	YES	NO
Has anyone in your family bled excessively after surgery or childbirth?	YES	NO
In your knowledge, does anyone in your family have a bleeding disorder including hemophilia, von Willebrand disease, low platelets, ITP or factor IV? If so, who and which one:	YES	NO

____