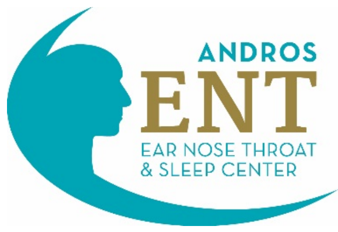


Andros ENT & Sleep Center

MINOR PATIENT REGISTRATION FORM Birth – 12 years

PLEASE PRINT

PATIENT INFORMATION				
Last Name First Name M.I.	DOB: / /	Age:	Sex: ☐ M ☐ F	
Social Security #:	Are Parents Divorced? ☐ YES ☐ NO	Patient's primary residence is with: ☐ Mother ☐ Father ☐ Both ☐ Other: __________	If divorced, shared custody? ☐ YES ☐ NO ☐ N/A	
If NO, describe limitations:				

PRIMARY PARENT/GUARDIAN INFORMATION			
Last Name First Name M.I.	DOB: / /	Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	Employer Name & Address:		

SECONDARY PARENT/GUARDIAN INFORMATION			
Last Name First Name M.I.	DOB: / /	Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	Employer Name & Address:		

INSURANCE INFORMATION		
Name of Policy Holder:	DOB: / /	Address of Policy Holder:
Relationship to Patient: ☐ Self ☐ Parent ☐ Other: ______________________________		
Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ____________		
Group Number:	Policy ID Number:	

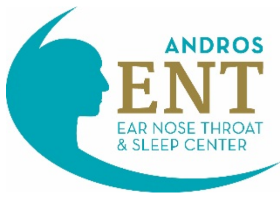
SECONDARY INSURANCE INFORMATION		
Name of Policy Holder:	DOB: / /	Address of Policy Holder:
Relationship to Patient: ☐ Self ☐ Parent ☐ Other: ______________________________		
Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ____________		
Group Number:	Policy ID Number:	

EMERGENCY CONTACT (CANNOT BE A PERSON LISTED ABOVE)		
Name:	Relationship:	Phone:

I certify that the above information is true to the best of my knowledge.

______________________________ ______________________________

Parent/Guardian Signature Date



Pediatric Visit

Patient Name:	**Today's Date:**

Primary care physician: ______________________________ Clinic: ____

Doctor who referred you: ______________________________ Clinic: ____

Reason for Today's Visit: ____

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: _______________________________________

Person completing form: ____

Legal guardian: ____ Date: ________________________________

Power of attorney: ____ Date: ________________________________

Past Medical History/Birth History

Method of delivery: _____Normal vaginal _____Cesarean section Intubated: Yes /No

Was born premature? Yes /No If yes, list gestational age at delivery: __________ weeks

Birth weight: _____ lbs. _____oz. Current weight: ________ lbs. Current height: ________ in.

Has child passed newborn hearing screening? Yes /No /Unsure

Please indicate any therapy child is receiving: _____ PT _____ OT _____Speech _____ Other (list):_____________

Immunization up to date: Yes /No , if no explain: ____

Please circle Yes or No to indicate if patient has any of the following illnesses; for YES please explain

Infections during pregnancy: Yes/No, if so: ____

Recurring/high fevers (>102): Yes/No, if so: ____

Complications during pregnancy: Yes /No

Hearing problems: Yes /No

Nasal congestion: Yes /No

Vision problems: Yes /No

Large tonsils: Yes /No

Immune deficiency: Yes /No

Reflux/spit up: Yes /No

Attention problems: Yes /No

Walked at age: _____ months

Neurological problems: Yes /No

Bedwetting: Yes /No

Chronic runny nose: Yes /No

Respiratory problems/asthma: Yes /No

Easy bruising/bleeding/epistaxis: Yes /No

Heart problems: Yes /No

High fever/surgery: Yes /No

Circumcised: Yes /No

Speech problems: Yes /No ______ # of words easily understood

Ear infections: Yes /No if yes, ______ # past 6-12 months, Right /Left /Both

Chronic sore throat: Yes /No if yes, Strep: Yes /No , Mono: Yes /No

Name: ______________________________

Please list all surgeries/operations (if not applicable please write N/A)

Type of Surgery	Date of Surgery

Social & Family History

1. Does child attend daycare? Yes /No
2. Are there pets in the house? Yes /No if yes, list number/types:______________________________________
3. Is there smoke exposure? Yes /No
4. Who does the child live with? (including siblings): ____
5. School grade: ______________________ list any special schools/classes:

Family History (check all that apply, if not applicable please write N/A)

	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								

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

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 current, if the symptoms relates to the reasons for your visit today and you would like to have it evaluated.

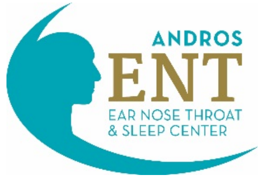
Allergy:

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:

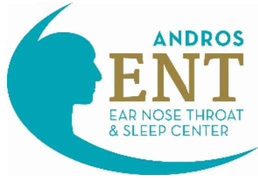
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White or Caucasian
- ☐ Multi-racial
- ☐ Choose not to disclose/ decline

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

____