

Andros ENT & Sleep Center

MINOR PATIENT REGISTRATION FORM 13-17 years old

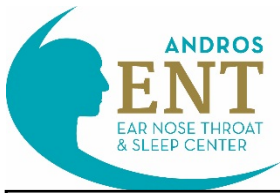
PLEASE PRINT

PATIENT INFORMATION					
Last Name	First Name	M.I.	DOB: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #:	Are Parents Divorced? <input type="checkbox"/> YES <input type="checkbox"/> NO	Patient's primary residence is with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other: _____		If divorced, shared custody? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____					
Insurance Company: <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Cigna <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> Other: _____					
Group Number:			Policy ID Number:		
SECONDARY INSURANCE INFORMATION					
Name of Policy Holder:	DOB: / /	Address of Policy Holder:			
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____					
Insurance Company: <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Cigna <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> 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



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

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:

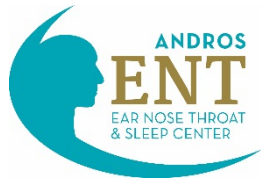
- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Multi-racial |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Choose not to disclose/ decline |
| <input type="checkbox"/> Native Hawaiian / Other Pacific Islander | |

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:

- | | | | | |
|----------------------------------|--|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> Amharic | <input type="checkbox"/> Arabic | <input type="checkbox"/> Bosnian | <input type="checkbox"/> Burmese | <input type="checkbox"/> Cambodian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> German | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Karen | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Oromo | <input type="checkbox"/> Polish | <input type="checkbox"/> Romanian |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Sign Language | <input type="checkbox"/> Somali | <input type="checkbox"/> Spanish | <input type="checkbox"/> Swahili |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Tibetan | <input type="checkbox"/> Tigrinya | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Yorba | <input type="checkbox"/> Other | Specify _____ | | <input type="checkbox"/> 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 YES NO

including hemophilia, von Willebrand disease, low platelets, ITP or factor IV?

If so, who and which one:



PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

This form authorizes Andros ENT & Sleep Center, PA to provide medical care or treatment to a minor who is accompanied to an office visit by an adult who is NOT the minor’s parent or legal guardian, ex.: a babysitter. This form also authorizes Andros ENT & Sleep Center, PA to provide care to a sixteen or seventeen year old child without an accompanying adult. Please review the authorization and complete if you wish to authorize such treatment. Note: The minor’s parent or legal guardian will have access the minor’s medical records unless law prohibits.

AUTHORIZATION

I appoint _____, _____
(Name) (Address)
_____, who is my child’s _____
(City, State, Zip) (Specify Nature of Relationship to Minor)

As my proxy decision maker for consenting to the delivery of medical care for my child,

_____, _____
(Name of Minor) (Minor’s Date of Birth)

In my absence.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization in given. If none, state “None”.

Identify any limitations on the time frame for which this authorization is given. If none, state “None”.

FOR MINORS SIXTEEN (16) OR SEVENTEEN (17) YEARS OF AGE:

I give my permission for “routine” treatment to be administered without my presence, or the presence of another accompanying adult as deemed necessary by the physician.

CONTACT INFORMATON

If the nature of the medical care is not routine or considered urgent, please contact me (us) regarding the healthcare of my child at the following phone numbers:

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Mobile Phone Number: _____ Mobile Phone Number: _____

Daytime Phone Number: _____ Daytime Phone Number: _____

I understand that this consent may be revoked at any time in writing to Andros ENT & Sleep Center PA.

Signature(s) of parent(s) or legal guardian(s):

_____/_____
Please Print Full Name Relationship

_____/_____
Please Print Full Name Relationship

_____/_____
Signature Date

_____/_____
Signature Date