ONSLOW
EAR NOSE & THROAT

55 Office Park Drive • Jacksonville, NC 28546
Phone: 910.219.3377 • Fax: 910.219.4227

REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

PATIENT'S FULL NAME:	DATE OF BIRTH:	AGE:	SEX: ○ M ○F RACE:
STREET ADDRESS:	SOCIAL SECURITY NUMBER		
CITY:	STATE:	ZIP CODE:	
PLACE OF WORK:	WORK ADDRESS:	JOB TITLE:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	
NAME OF PERSON NOT LIVING WITH YOU TO CONTACT FOR EMERGENCY:	PHONE:		
REFERRED TO CLINIC BY:			

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME:	POLICY ID /TRICARE SPONSOR SOCIAL SEC. #:	GROUP#/TRICARE SPONSOR D.O.B
INSURED'S NAME:	PATIENTS RELATION TO SUBSCRIBER: ○SELF ○SPOUSE ○CHILD ○OTHER	
SECONDARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SEC. #:	GROUP#/TRICARE SPONSOR D.O.B:
INSURED'S NAME:	PATIENT'S RELATION TO SUBSCRIBER: ○SELF ○SPOUSE ○CHILD ○OTHER	

REQUIRED SIGNATURE

I have been provided with the following documents from Onslow Ear, Nose and Throat: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice's website. (www.onslowent.org)

I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow ambulatory Services, Inc.

(For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Onslow Ear, Nose and Throat). I understand that I am personally responsible for all charges not covered by my insurance.

Patients Signature:_____ **Date:**_____

Patient Portal allows you to have access to Appointments, Lab results, Medication refill, Medical Records and more.

If you are interested please provide your EMAIL below:

E-Mail:_____

ONSLOW
EAR NOSE & THROAT
Onslow
Matthew Bolinger, MD
55 Office Park Drive, Jacksonville, NC. 28546
PHONE 910-219-3377 ● Fax 910-219-4227

NAME:	Date of Birth

ALLERGIES (MEDICATIONS, X-RAY DYES, LATEX) * PLEASE STATE TYPES OF REATION)

PRESCRIPTION MEDICATIONS-NAME, DOSAGE ○ SEE LIST *REMEMBER TO BRING ALL MEDICATIONS TO FUTURE VISITS		

SOCIAL HISTORY

DO YOU USE TOBACCO PRODUCTS?
○FORMER ○NEVER ○YES_____ PER DAY_____ YEARS

DO YOU DRINK ALCOHOL?
○FORMER ○NEVER ○YES_____ TYPE_____AMOUNT (CIRCLE ONE: DAILY, WEEKLY, MONTHLY)

PAST MEDICAL HISTORY

PREGNANT OR THINK YOU MAY BE PREGNANT? ○YES ○NO *PLEASE LET US KNOW IF YOU PREGNANCY STATUS CHANGES

○ ACID REFLUX (GERD)	○ BIRTH DEFECT	○ DEVELOPMENTAL DELAY	○ KIDNEY DISEASE	○ SLEEP APNEA
○ ANEMIA	○ BLEEDING/CLOTTING DISOF	○ DIABETES	○ LIVER CIRRHOSIS	○ STROKE/TIA
○ ANXIETY	○ CANCER TYPE:	○ HEART DISEASE	○ MIGRAINES	○ THYROID DISORDER
○ ASTHMA	○ COPD/EMPHYSEMA	○ HIGH BLOOD PRESSURE	○ SEASONAL ALLERGIES	○ TINNITUS
○ AUTOIMMUNE DISORDER	○ DEPRESSION	○ INSOMNIA	○ SEIZURES	○ VERTIGO/DIZZINESS

OTHER:

PAST SURGICAL HISTORY

○ EAR TUBES	○ SEPTOPLASTY	○ TYMPANOPLASTY	○ HEAD/ NECK CANCER SURGERY	○ EYE SURGERY
○ TONSILLECTOMY	○ TERBINATE REDUCTION	○ MASTOID SURGERY	○ HEART SURGERY	○ OTHER:
○ ADNOIDECTOMY	○ SINUS SURGERY	○ SLEEP APNEA SURGERY	○ PACEMAKER PLACEMENT	

FAMILY HISTORY ○ADOPTED (PLEASE SKIP THIS SECTION) * PLEASE ONLY LIST BLOOD RELATED FAMILY MEMBERS

	FATHER	MOTHER	SIBLING(S)	CHILD(REN)
ANESTHESIA PROBLEM	○	○	○	○
BLEEDING/CLOTTING DISORDER	○	○	○	○
CANCER /LIST TYPE	○	○	○	○
HEART DISEASE	○	○	○	○
HEARING DISORDER	○	○	○	○
OTHER:	○	○	○	○

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU:

EAR PROBLEMS	NOSE PROBLEMS	THROAT PROBLEMS
○ EAR ACHE ☺ RIGHT ☺ LEFT	○ STUFFINESS/BLOCKAGE	○ SORE THROAT
○ DIZZINESS/VERTIGO	○ POSTNASAL DRIP/RUNNY NOSE	○ SWOLLEN GLANDS
○ INJURY TO EAR	○ NOSE BLEEDS	○ HOARSENESS
○ EAR DRAINAGE	○ SNORING	○ COUGHING UP BLOOD
○ HEARING LOSS ☺ GRADUAL ☺ SUDDEN	○ LOSS OF SMELL	○ DIFFICULTY SWALLOWING
○ RINGING IN EARS	○ SNEEZING	○ BAD BREATH
○ OTHER	○ OTHER	○ OTHER

ACKNOWLEDGEMENT OF RECEIPT OF ONSLOW AMBULATORY SERVICES,INC. NOTICE OF PRIVACY PRACTICES

I acknowledge that I was made aware of the Notice of Privacy Practices of Onslow Ambulatory Services (including, but not limited to, Central Coast Dermatology Jacksonville Internal Medicine, Eastern Carolina Orthopedic Clinic, Onslow Primary Care & Sports Medicine, and Onslow ENT) (hereinafter referred to as OAS) on_____(date). I understand that the Notice describes the uses and disclosures of my protected health information by Onslow Ambulatory Services and informs me of my rights with respect to my protected health information.

For more information, please contact the Onslow Ambulatory Service's HIPAA Privacy Officer at 910-577-2852.

Patients Address:_____

Signature of Patient/Personal Representative:_____

Printed Name of Patient/Personal Representative:_____

If Personal Representative, Indicate Relationship:_____

Date:_____

__Patient refused to sign or patient deferred signing until further review.

Hospital Representative Inititals_____

Onslow Ear Nose & Throat

PATIENT/INSURED AGREEMENT

In an effort to provide clear communication with our patients, please be advised as follows:

- The contractual agreement for your medical benefits is between you and the insurance company. We provide billing as a courtesy.
- For all insurance companies that we have a contractual agreement with, we will accept the "In-Network" benefits as outlined on the individual Explanation of Benefits. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all insurance companies that we *DO NOT* have a contractual agreement with, we will accept the "Out-of-Network" benefits, if such benefits are available. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all non-contracted insurance companies, you (the patient/insured) will be responsible for all charges in accordance with Onslow Ear Nose & Throat "Private Pay" fee schedule.
- When insurance benefits have been exhausted and/or terminated, you (the patient/insured) will be responsible for the charges incurred in accordance with Onslow Ear Nose & Throat "Private Pay" fee schedule.
- We cannot verify if all services/modalities will be covered by a particular benefit plan. *THIS IS YOUR (THE PATIENT/INSURED'S) RESPONSIBILITY!*
- In all cases, you (the patient/insured) will be responsible for any non-covered services, deductibles, co-pays and coinsurance amounts deemed as patient responsibility by your insurance company.

THIS AGREEMENT SUPERSEDES ALL OTHER VERBAL AGREEMENTS

I have read and agree to be financially responsible for all services both COVERED and NON COVERED by my insurance company.

_____ _____

PATIENT/INSURED SIGNATURE DATE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note if you wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information such as test results (including HIV/AIDS), pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time..

Patient Name:_____ **Date of Birth:**_____

Do NOT release information about:_____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Patient Signature: _____ **Date Signed:**_____

PHONE RELEASE

I authorize Onslow Ear, Nose and Throat to leave a message with anyone that answers my phone or on my answering machine in regards to any up coming appointments, or issues in regard to my care.

Patient Signature: _____ Date Signed:_____

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No Show/ Cancellation Policy

Due to the number of patients requesting specific appointment times at Onslow Ear, Nose and Throat our No Show/ Cancellation Policy is:

You will be charged a **$25.00** No Show/Cancellation fee if:

- You do not call to cancel **24 hours** prior to your appointment
- You do not check in at front before your appointment time (you should plan to be here 15 minutes before your appointment time to complete paperwork)
- In order to ensure our schedule remains on time, if you are **10 minutes** late for your appointment, **YOU WILL BE RESCHEDULED.**
- You may call our office at (910) 219-3377 and leave a message to cancel your appointment. Our answering service WILL place a time stamp on your message.
- Having THREE (3) No Shows within a six month period, beginning from the date of the first No Show **may prevent you from being able to schedule further appointments.**

Our main goal is to provide excellent patient care and customer service so we thank you for your understanding in this matter.

_____ _____

Signature Date

_____ _____

Witness Date

Patient has refused to sign_____

PATIENT UNDERSTANDS THAT REGARDLESS OF SIGNATURE THEY WILL BE CHARGED A $25.00 NO SHOW/CACELLATION FEE THROUGH MED BILL.

Onslow ENT Office Staff