ONSLOW
EAR NOSE & THROAT

55 Office Park Drive • Jacksonville, NC 28546
Phone: 910.219.3377 • Fax: 910.577.4983

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:____

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Patient Name:_______________________________ **Date of Birth:** _____________ **Age:**_____

Gender: ☐Male ☐Female **Race:**_____

Chief Complaint:_______________________________

PHARMACY INFORMATION	**Name:**_______________________ **Phone:**_______________ **Address:**_______________________

Primary Care Provider:_______________________ **Doctor who referred you here:** _______________

PAST MEDICAL HISTORY

☐ ADD	☐ Diabetes, Type I	☐ Heart Disease	☐ Nasal Obstruction
☐ Anemia	☐ Diabetes, Type II	☐ High Blood Pressure	☐ Sinusitis
☐ Anesthesia Problems	☐ Dizziness	☐ Hoarseness	☐ Sleep Apnea
☐ Asthma	☐ Ear Infections	☐ Insomnia	☐ Snoring
☐ Bleeding	☐ Food Allergies	☐ Kidney Disease	☐ Strep Throat
☐ Cancer (skin, thyroid, etc) Type:_____________	☐ Gastric Reflux	☐ Liver Disease	☐ Stroke
☐ Depression	☐ Headaches	☐ Lung Disease	☐ Thyroid Disorder
☐ Developmental Delay	☐ Hearing Loss	☐ Migraine Headaches	☐ Tinnitus

PAST SURGICAL HISTORY

☐ Ear Tubes	☐ Vocal Cord Surgery
☐ Neck Surgery (thyroid)	☐ Heart Surgery
☐ Sinus Surgery/ Nasal Surgery	☐ Sleep Apnea Surgery
☐ Tonsillectomy/ Adenoidectomy	☐ Other:_____________

MEDICATION HISTORY

List of current medication and dosage: _______________________________________

____

DRUG ALLERGIES

○ NO KNOWN ALLERGIES ☐ YES: please list and include reaction

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	CHILD(REN)
ANESTHESIA PROBLEM	☐	☐	☐	☐
BLEEDING/CLOTTING	☐	☐	☐	☐
CANCER-LIST TYPE	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HEARING LOSS/DISORDER	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
THYROID DISEASE/CANCER	☐	☐	☐	☐

PAST HOSPITALIZATION:

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SOCIAL HISTORY

Alcohol Usage	Tobacco Usage	Other
□ Currently Every Day Amount:_______ Type:________	□ Currently Every Day Amount: _____ Type:___________	□ Prior or Current Recreational Drug Use
□ Currently Some Days □ Former Age Quit: _____ □ Never	□ Currently Some Days □ Former Age Quit:______ □ Never	□ Other Risk Factors for HIV Explain: ________________ □Occupation:____________________

REVIEW OF SYSTEMS

Please check all symptoms which you have presently or have had recently.

CONSTITUTIONAL SYMPTOMS

□Fatigue □ Fever □ Difficulty Sleeping

□ Other: ___________________________________

NEUROLOGIC SYMPTOMS

□Speech Difficulties □ Migraines □ Dizziness

□ Headaches □ Seizures □ Numbness/tingling

□ weakness □Other: _______________

EAR SYMPTOMS

□Earache □right □ left □Dizziness/Vertigo

□Injury to ear □right □left □Ear Drainage □right □left

□Hearing Loss □Ringing in the ears □right □left

□ Other:___________________

NOSE SYMPTOMS

□Stuffiness/blockage □Postnasal drip/Runny nose

□Nose Bleed □Snoring

□Loss of smell □Sneezing

□Other:___________________

THROAT/ NECK SYMPTOMS

□Sore Throat □Swollen glands □Hoarseness

□Difficulty swallowing □Coughing up blood

□Bad breath

GASTROINTESTINAL SYMPTOMS

□Heartburn □Reflux □Choking on liquids

□Other:____________________

ENDOCRINE SYMPTOMS

□History of Thyroid problems

□Weight Loss □Weight gain

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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.

______________________________ SIGNATURE

____________ DATE

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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, Onslow Primary Care & Sports Medicine, and Onslow ENT) (Here in after 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 @ 910-577-2852

Patients address:____

Signature of Patient/Personal Rep.:____

Printed Name Of Patient/Personal Rep:____

Date:_________________

___ Patient refuses to sign or patient deferred signing until further review.

Hospital Representative Initials:__________