ONSLOW
EAR NOSE & THROAT

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

PEDIATRIC REGISTRATION FORM (PLEASE PRINT)

PEDIATRIC REGISTRATION			
PATIENT'S FULL NAME:	DATE OF BIRTH:	AGE:	SEX: ⊙M ○F RACE:
STREET ADDRESS:	SOCIAL SECURITY:		
CITY:	STATE:	ZIP CODE:	CELL:
FATHER'S NAME:	SOCIAL SECURITY:	DATE OF BIRTH:	BUSINESS/CELL PHONE:
FATHER'S PLACE OF EMPLOYMENT:	WORK ADDRESS:		JOB TITLE:
MOTHER'S NAME:	SOCIAL SECURITY:	DATE OF BIRTH:	BUSINESS/CELL:
MOTHER'S PLACE OF EMPLOYMENT:	WORK ADDRESS:		JOB TITLE:
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:			PHONE:
REFERRED TO CLINIC BY:			

INSURANCE INFORMATION		
PRIMARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SECURITY:	GROUP#/ TRICARE SPONSOR D.O.B
INSURED'S NAME:	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ○SELF ○SPOUSE ⊙CHILD ○OTHER	
PRIMARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SECURITY:	GROUP#/ TRICARE SPONSOR D.O.B
INSURED'S NAME:	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ○SELF ⊙SPOUSE ○CHILD ○OTHER	

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN	
I GIVE MY PERMISSION FOR THE PHYSICIANS @ ONSLOW EAR, NOSE AND THROAT TO PROVIDE ANY NECESSARY MEDICAL CARE TO MY MINOR CHILD WHOSE NAME IS:	
NAME OF LEGAL PARENT/GUARDIAN:	PARENT/GUARDIAN SIGNATURE:

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 Practice. These documents are also available online at the practice's website (www.onslowent.org)

I authorize the release of information concerning my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for the 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 life time 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.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Patient Portal allows you to have access to Lab results, 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

Pediatric exposed to smoke?(Cigarette/Vape) ☐Yes ☐No Does patient smoke? ☐Yes ☐No ☐Alcohol usage during pregnancy ☐Drug usage during pregnancy	☐Daycare/Preschool ☐Grade in School: ____	Other ☐Loss of School Time in Past Year How Much? _____ ☐Pacifier Use ☐Siblings How Many? _____

REVIEW OF SYSTEMS

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

CONSTITUTIONAL SYMPTOMS

☐Fatigue ☐Fever ☐Difficulty Sleeping

☐Bed Wetting ☐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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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 number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact number: _____

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 upcoming appointments, or issues in regards to my care.

Signature: _____ Date Signed: _____

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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 incurred in accordance with Onslow Ear Nose and 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 and 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) RESPONSIBILITY!***
- In all cases, you 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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Pre-Authorization for Medical Care to Children

In the event that you are unable to accompany your minor child to an office visit please provide the name(s) of the individual(s) eligible to authorize care for your child.

NAME	PHONE #	RELATIONSHIP TO CHILD

Please review the following authorization for treatment and complete the information if you wish to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize *Onslow Ear, Nose and Throat* and it's personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT:

Today's Date: _____

Child's Name: _____ **Child's Date of Birth:** _____

Parent/Guardian Name: _____

Relationship to child: _____

Telephone Number: Home: _____ **Cell:** _____

Signature of Parent/Guardian: _____