Boston ENT Associates
Patient Registration Form

Todays Date: ____________

Name / Address

Last Name: ___________________ ________ First Name: ______________ __________ MI: _______
Home Address1: _________________________________ Home Phone (____) _____-_________
Address2: _________________________________ Email:___________________
City: __________________________ State: _____ Zip ______-_____

Statistics

Soc. Sec. #: _____-____-_______ Date of Birth: _______________
Cell Phone (___)_____-_______ Sex: Male / Female
Employer: ___________________ Work Ph. (___)_____-_______

Marital Status (circle one)
Married, Single,
Divorced, Widow, Oth.

Spouse / Next of Kin: _______________________ Next of Kin Phone: (____) ____-_________
Responsible Party: _______________________________

Referring Physician

Primary Care Doctor: _______________________ Referring MD: ___________________

Insurance Information

Primary Insurance Company	Identification or Certificate #	Group Number

Name of insured if not self: ______________________

Relation to Insured
Self, Spouse, Child

Insured Date of Birth: _______________
Insured Soc. Sec. ______________
Insured Employer: ________________________

Employment Status:
Full Time Part-time Student Other

Second Insurance Company	Identification or Certificate #	Group Number

Name of insured if not self: ______________________

Relation to Insured
Self, Spouse, Child

Insured Date of Birth: _______________
Insured Soc. Sec. ______________
Insured Employer: ________________________

Other Insurance

Is this Workers Comp.? Y / N Motor Vehicle Accident? Y / N Is this Personal Injury? Y / N

Authorization and Financial Policy:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS.

I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO BOSTON ENT ASSOCIATES FOR SERVICES PROVIDED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL BALANCES NOT PAID BY MY INSURANCE COMPANY.

Your Signature: ________________________________

R. William Mason, M.D.
Joshua Kessler, M.D.
Rebecca Stone, M.D.

BOSTON ENT ASSOCIATES

Have you ever had trouble with … (Please Circle Specific Problem)

		Yes	*No*
1	Your breathing or lungs, asthma, bronchitis, emphysema, pneumonia, tuberculosis, abnormal chest x-ray, recent colds or wheezing or coughing?		
2	Your heart, heart attacks, chest pain or angina, shortness of breath, pressure in your chest, palpitations or irregular heartbeat, abnormal electrocardiogram?		
3	Not being able to walk up two flights of stairs without stopping to catch your breath?		
4	Rheumatic fever or mitral valve prolapse or been told that you have a heart murmur or click?		
5	Have you been told to regularly take antibiotics before dental care?		
6	Ulcers, gastritis, a hiatus hernia, frequent heartburn, yellow jaundice, hepatitis?		
7	Epilepsy, seizures, strokes, dizzy or fainting spells, weakness in arms or legs, muscle disease?		
8	Your blood pressure or are you taking medicines for your blood pressure?		
9	Your kidneys, or do you take diuretics or water pills?		
10	Bleeding, blood clots, frequent nose bleeds, anemia, or do you have sickle cell anemia?		
11	Thyroid disease or been told you have diabetes or high blood sugar?		
12	Cancer, or received chemotherapy or radiation therapy?		

Have you ever…

1	Had allergies to drugs or dyes? What type of reaction? ☐ Rash ☐ Hives ☐ Nausea ☐ Swelling ☐ Trouble breathing		
2	Smoked cigarettes? If yes, how many packs per day ____ week _____ How many years? _____ Do you smoke now? ________		

1	Do you drink alcohol? How many glasses each day? ___________ Week_______ Month_______		
2	What medicines have you been taking during the past month? (Please include aspirin, AlkaSelzer, Birth Control pills, etc.)		
3	What herbal supplements have you been taking during the past month? (i.e. St. John's Wort, Ginko Biloba, etc.)		
4	Have you taken steroids (Prednisone or Cortisone) during the past six months?		
5	Are you pregnant?		

_______________________________________ _____________________________

Patient Signature ***Date***

BOSTON ENT ASSOCIATES R.William Mason M.D. Joshua Kessler M.D. Rebecca Stone M.D. William P. Innis M.D.

Name: Age:

Date of Birth: Today's Date:

Primary Care Physician:

What is your primary reason for your visit today?

Have you had any testing relevant to your visit today? (CT scan, MRI, hearing test, etc.) :

MEDICATIONS: Please circle NONE if applied

Please list current medications or provide list: or NONE

Please list any **ALLERGIES** to medications or anesthesia: or NONE

Name and location of your pharmacy:

MEDICAL HISTORY: please circle all that apply

Do you have a history of (please circle):
High Blood Pressure Asthma Heart Disease Diabetes or NONE

Please list any other medical conditions you may have: or NONE

Do you have a family history of: hearing loss under the age of 65, cancer of the head or neck, bleeding disorder? or NONE

Any operations of the Head or Neck please list: or NONE

Have you ever had general anesthesia? YES or NO
Please list your height and weight: ______ lbs ____ft.____inches

Social History:

Do you currently smoke? If so, how much?
Have you smoked in the past? If so, how much?
Do you currently drink alcohol? If so, how much?
Did you drink alcohol in the past? If so, how much?

PATIENT CONSENT FORM

Our Notice of Practice provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected healthy information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Practice.
The patient reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by ____
(printed name of patient or representative)

____ ______
(signature) **(date)**

Relationship to Patient if other than patient ___________________________