**ENT SPECIALISTS, LTD.**

## PATIENT REGISTRATION FORM

(PLEASE PRINT)

WHO MAY WE THANK FOR REFERRING YOU: ______ PRIMARY MD : ______

| NAME: | | DATE OF BIRTH: |
|---|---|---|
| ADDRESS: | CITY: | ZIP: |
| HOME PHONE: | WORK PHONE: | |
| EMAIL | SEX: M F | MARITAL STATUS: |
| PHARMACY NAME AND LOCATION: | | |

**POLICY HOLDER INFORMATION**

| NAME: | DATE OF BIRTH: |
|---|---|
| ADDRESS: | |
| HOME PHONE: | |
| PATIENTS RELATIONSHIP TO POLICY HOLDER: SPOUSE CHILD OTHER: | |

***PLEASE PRESENT INSURANCE CARDS ALONG WITH PICTURE ID FOR COPYING***

COPAY AMOUNT: ______

| PRIMARY INSURANCE NAME: | | PHONE NUMBER: |
|---|---|---|
| IDENTIFICATION NUMBER | | GROUP NUMBER: |
| IS THIS CLAIM DUE TO WORKMANS COMP? | Y N | CONTACT PHONE NUMBER: |
| CLAIM NUMBER: | | |

EMERGENCY CONTACT: ______ PHONE NUMBER: ______ RELATION: ______

*CONSENT FOR EXAMINATION AND TREATMENT: *I, HEREBY AUTHORIZE THE HEALTH CARE PROVIDER AT ENT SPECIALISTS,LTD TO EXAMEN, ADMINISTER TREATMENT; MEDICAL OR SURGICAL, DEEMED NECESSARY OR ADVISABLE.*

SIGNATURE: ______ DATE: ______

*FINANCIAL AGREEMENT: *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.*

SIGNATURE: ______ DATE: ______

ENT SPECIALISTS, LTD.
57 EAST OGDEN AVENUE, CLARENDON HILLS, IL 60514

**Please fill out the following information as completely as possible. Thank You.**

**DATE/FECHA DE HOY:** ________________

**NAME/NOMBRE DEL PACIENTE:** ________________________ **DOB/FECHA DE NACIMIENTO:** __________

**PRIMARY DOCTOR/DOCTOR PRIMARIO:** ______________________________

**LIST PAST AND PRESENT MEDICAL PROBLEMS/SURGERIES:**
**ENLISTE SUS PROBLEMAS MEDICOS PASADOS Y PRESENTES:**

______________________________________________________________

______________________________________________________________

**REVIEW OF SYSTEMS/FAMILY HISTORY**
**HISTORIAL FAMILIAR**

**DO YOU OR YOUR IMMEDIATE FAMILY HAVE A HISTORY OF?**
**USTED O ALGUIEN EN SU FAMILIA INMEDIATA TIENE HISTORIAL DE:**

| | SELF/USTED | FAMILY/FAMILIA |
|---|---|---|
| CORONARY ARTERY DISEASE/ENFERMEDADES EN LAS ARTERIAS | ________ | ________ |
| STROKE/DERRAME CEREBRAL | ________ | ________ |
| DIABETES | ________ | ________ |
| KIDNEY DISEASE/ENFERMEDADES DEL RINON | ________ | ________ |
| CANCER | ________ | ________ |
| LUNG DISEASE/ENFERMEDADES DEL PULMON | ________ | ________ |

OTHER/OTRA ENFERMEDAD NO MENCIONADA: ________________________________

**LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING/ENLISTE MEDICAMENTOS QUE ESTE TOMANDO:**

______________________ ______________________

______________________ ______________________

**DO YOU HAVE ANY ALLERGIES TO MEDICATIONS/TIENE ALERGIAS HACIA ALGUN MEDICAMENTO?**
YES/SI NO
IF YES, **PLEASE LIST**/ENLISTE: ________________________________

**DO YOU DRINK ALCOHOL? - TOMA ALCOHOL?** YES/SI NO
HOW MANY DRINKS PER WEEK? - CUANTO TOMA POR SEMANA? ____________________

**DO YOU SMOKE? - FUMA?** YES/SI NO
HOW MANY PACKS PER WEEK? –CUANTOS PAQUETES POR SEMANA? ____________________

**DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? – TIENE HISTORIAL DE USO DE SUSTANCIAS TOXICAS?**
YES/SI NO
IF YES, PLEASE LIST THEM/ENLISTE ________________________________

**DO YOU HAVE ANY PETS? / TIENE ALGUNA MASCOTA?** YES/SI NO
WHAT TYPE/QUE TIPO? ____________________

**ENT SPECIALISTS, LTD.**
57 East Ogden Avenue
Clarendon Hills, Il 60514
(630) 495-6000
(630) 495-6001 Fax

# Receipt of Notice of Privacy Practices Form

I, ________________________________, hereby acknowledge receipt of the
(Patients' Name)

Physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Sign : ____________________________ Date: __________________

If you are not the patient, please specify your relationship to the patient__________________

-Patient file