PATIENT REGISTRATION	**NEW YORK OTOLARYNGOLOGY GROUP**

Patient Information:		
Last Name:	First Name:	Middle:
Date of Birth:	Gender *(circle one)*: Male Female Other	
Address:		Apt. #
City:	State:	Zip:
Home Phone:	Work:	Cell:
Email address:	**Preferred Contact** *(circle one)*: Phone Call Text Email	
Do you need an Interpreter: Y N	Preferred Language:	
*Race *(circle one)*: American Indian / Asian / Black or African American / Caucasian / Other / Declined *Ethnicity *(circle one)*: Hispanic / Non- Hispanic / Declined		
Marital Status:		
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #:		

Physician Information:	
Primary Care MD Name:	Phone #:
Referring MD Name:	Phone #:
Pharmacy Name:	Phone #:

Guarantor Information: (*Person to be billed, if different from patient*)		
Last Name:	First Name:	Middle:
Date of Birth:	Employer:	
Address:		Apt. #
City:	State:	Zip:
Home Phone:	Work Phone:	Cell:

Insurance/Coverage Information:		
Primary Insurance:	ID #:	Group #:
Insured's Last Name:	First:	DOB:
Secondary Insurance:	ID #:	Group #:
Insured's Last Name:	First:	DOB:

**The Centers for Medicare and Medicaid Services (CMS) require that we collect the following additional demographic information. Be assured that any information that WCPN collects related to race, ethnicity or language is used to provide care tailored to the needs of each patient*

Patient Clinical Information:			
Last Name:	First Name:	Middle:	Date of Birth:
Reason for Visit:			
Medications: (List all that you are taking)			
Allergies: (To Medications or Substances)			
Social History:			
Do you smoke? *(circle one)*: Y N **Did you smoke?** *(circle one)*: Y N		**If Yes** *(circle one)*: Cigarettes Cigars Pipe	
If you ever smoked, when did you stop? _____			
Do you drink? *(circle one)*: Y N	**If so, how many per day?** _____		
Do you ever or have you ever used IV drugs? *(circle one)*: Y N			

Past or Current Medical Illnesses: *check all that apply*			
Hypertension (High Blood Pressure) __	Bleeding Disorder __	Lung Disease (COPD, Asthma) __	Environmental Allergies __
Neurological Disorder __	Heart Disease __	Kidney Disease __	Elevated Cholesterol __
Arthritis __	Glaucoma __	Thyroid Disease __	Stroke __
HIV __			
Do you have a Pacemaker ? *(circle one)*: Y N		Any problems with hearing **?** *(circle one)*: Y N	

Hospitalizations / Surgeries:	**Reason for Hospitalization / Type of Surgery:**
Year: _____ Reason _____	
Year: _____ Reason _____	

Family History: Please *check if your relatives have had:*		
Hypertension __	Anemia __	Cancer (type):
Stroke __	Asthma __	
Heart Disease __	Autoimmune Disease __	Other:
Diabetes __	Hearing Loss __	

Review of Systems: Do you experience any of the following? *check all that apply*			
CONSTITUTIONAL	EYES	GASTROINTESTINAL	ENDO/HEME/ALLER
Fever __	Blurred Vision __	Heartburn __	Easy Bruise/Bleed __
Chills __	Double Vision __	Nausea __	Env Allergies __
Weight Loss __	Photophobia __	Vomiting __	Polydipsia __
Malaise/Fatigue __	Eye Pain __	Abdominal Pain __	NEUROLOGICAL
Diaphoresis __	Eye Discharge __	Diarrhea __	Dizziness __
Weakness__	Eye Redness __	Constipation __	Tingling __
SKIN	CARDIOVASCULAR	Blood in Stool __	Tremor __
Rash __	Chest Pain __	Melena __	Sensory Change __
Itching __	Palpitations __	GENITOURINARY	Speech Change __
HENT	Orthopnea __	Dysuria __	Focal Weakness __
Headaches __	Claudication __	Urgency __	Seizures __
Hearing Loss __	Leg Swelling __	Frequency __	LOC __
Tinnitus __	PND __	Hematuria __	PSYCHIATRIC
Ear Pain __	RESPIRATORY	Flank Pain __	Depression __
Ear Discharge __	Cough __	MUSCULOSKELETAL	Suicidal Ideas __
Nosebleeds __	Hemoptysis __	Myalgias __	Substance Abuse __
Congestion __	Sputum Production __	Neck Pain __	Hallucinations __
Stridor __	Shortness of Breath __	Back Pain __	Nervous/Anxious __
Sore Throat __	Wheezing __	Joint Pain __	Insomnia __
		Falls __	Memory Loss __

Patient's Signature: _____ **Date:** _____