

PATIENT REGISTRATION

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT. All information will be kept confidential.

NAME LAST FIRST MI BIRTHDATE SEX
PLEASE PROVIDE P.O. BOX AND HOME ADDRESS

P.O. BOX: CITY STATE ZIP

ADDRESS:

CITY STATE: ZIP:

HOME PHONE #: WORK #: CELL #:

SOCIAL SECURITY #: OCCUPATION:

NAME OF EMPLOYER:

SPOUSE OR PARENT INFORMATION

NAME: RELATIONSHIP HOME PHONE#:

EMPLOYER: WORK PHONE#:

INSURANCE INFORMATION

PRIMARY INSURANCE:

I.D.#: GROUP#:

SUBSCRIBER'S NAME: RELATION TO PT:

SECONDARY INSURANCE:

I.D.#: GROUP #:

SUBSCRIBER'S NAME RELATION TO PT:

EMERGENCY CONTACT: PHONE#:

NAME OF REFERRING PHYSICIAN: PHONE#:

ARE YOU ALLERGIC TO ANY MEDICATION(S)?

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By my signature below I acknowledge receipt of South Seattle Otolaryngology, Proliance Surgeons Privacy Practices

Signature Relationship to Patient Date

Assignment, Release and Financial Agreement: I authorize my insurance benefits to be paid directly to the doctor. I understand that my insurance (including Medicare) may not cover all the services/supplies received on my behalf and I am financially responsible for any balance due and/or not covered by my insurance. I authorize the doctor or insurance company to release any information required for this claim.

Signature Relationship to Patient Date

South Seattle Otolaryngology is pleased to now offer patients professional services by electronic means - Telephone and Fax. Requests for services from Dr. McClean, Dr. Green or Dr. Maurice may be made by telephone or fax.

Electronic Services and Benefits: Medication refills will be charged at \$15.00, other electronic services are subject to a \$25 minimum charge and are other wise prorated at an hourly rate. You will be notified prior to a service being rendered if a charge of more than \$100 is anticipated. These charges do not apply to postoperative patients for 90 days post surgery, but otherwise are the responsibility of the patient.

Signature Relationship to Patient Date

South Seattle Otolaryngology
 Head and Neck Surgery
 16259 Sylvester Road S.W.
 Suite 505
 Seattle, Washington 98166
 (206) 242-3696

Patrick H. McClean, M.D., F.A.C.S.

South Seattle Hearing Aids

David C. Green, M.D., F.A.C.S.

Vanessa Rentschler, M.S., CCC-A

Peter F. Maurice, M.D., F.A.C.S.

Patient Chief Complaint

Billie Garber, M.S., CCC-A

Patient Name: _____

Date of initial visit: ___/___/___

Date of birth: ___/___/___

Referring Physician: _____

Reason for today's visit? _____

When did the symptoms first begin? _____

Did anything specific cause the problem to begin? _____

What makes it better? _____

Worse? _____

PLEASE LIST ALL DRUG ALLERGIES: _____

Patient Health History

Please put an "X" if the patient is being treated for any of the following:

- Asthma
- Chest Pain/ Heart Attack
- Chronic Bronchitis
- Congestive Heart Failure

- Diabetes
- Emphysema
- High Blood Pressure

- Peptic Ulcers/ Gastritis
- Problems with Blood Clotting
- Thyroid Problems

Please list any prior hospitalizations or surgeries (include date, reason for hospitalization or surgery, surgery performed, and the hospital to which you were admitted).		
Current Medication(s)	Dose	Frequency



Patient Name: _____

Date of Birth: ____ / ____ / ____

Family History

Please circle one:

Family Member (in relationship to patient)	Alive	Deceased	Age	Health problems or Cause of death
Grandmother (Maternal)	A	D		
Grandfather (Maternal)	A	D		
Grandmother (Paternal)	A	D		
Grandfather (Paternal)	A	D		
Father	A	D		
Mother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		
Sister/ Brother	A	D		

Have you or a family member ever been diagnosed with a bleeding disorder? Yes No

If yes, please describe: _____

Social History (Fill out if patient is a Minor)

Who lives at home with your child? _____

Does your child attend school or daycare? Yes No

How many children are in the class? _____

Is your child exposed to cigarette smoke? Yes No

Is your child at risk for HIV or other blood-borne diseases? No Yes

If yes, please explain: _____

Social History (Fill out if patient is an Adult)

Occupation: _____

Marital Status: Single Married Divorced Widowed

Do You Have children: Yes No How many? _____

Do you live alone Yes No Who lives with you? _____

Do you smoke Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes I smoke cigars or a pipe Yes, I use smokeless tobacco No, I've never smoked

No, I quit _____ years ago. At that time I was smoking _____ pack a day for _____ years

Do you drink alcohol? No, never (rarely) No, but I used to

Yes Daily 1 or more times a week 1 or more times a month

Are you at risk for HIV or other blood-borne diseases? No Yes

If yes please explain _____

If you are female, When was the first day of your last menstrual period? ____ / ____ / ____

Patient Name: _____

Date of Birth: ____/____/____

Review of Systems

Are you currently having problems with or being treated for the following?

<i>General</i>	<i>Circle One</i>		<i>Cardiovascular</i>	<i>Circle One</i>
Fever	Yes No		Irregular pulse	Yes No
Weight loss	Yes No		Heart murmur	Yes No
Night Sweats	Yes No		Swelling in feet	Yes No
			Leg pain	Yes No
<i>Skin</i>			<i>Gastrointestinal</i>	
Skin disease	Yes No		Indigestion or pain	Yes No
Skin cancer	Yes No		Nausea	Yes No
			Vomiting	Yes No
<i>Eyes, Ears, Nose, Throat and Mouth</i>			Blood in your vomit	Yes No
Liver disease	Yes No			
Injuries	Yes No		Jaundice	Yes No
Glaucoma	Yes No		Colon cancer	Yes No
Cataracts	Yes No			
Wear hearing aids	Yes No		<i>Genitourinary</i>	
Hearing loss	Yes No		Urinary tract infections	Yes No
Ear pain	Yes No		Painful urination	Yes No
Ear infections	Yes No		Blood in urine	Yes No
Ringing in ears	Yes No		Incontinence	Yes No
Balance disturbance	Yes No		Kidney stones	Yes No
Nosebleeds	Yes No			
Nasal congestion	Yes No		<i>Musculoskeletal</i>	
Nasal drainage	Yes No		Broken bones	Yes No
Inability to smell	Yes No		Arm or leg weakness	Yes No
Sinus problems	Yes No		Back pain	Yes No
Sinus headaches	Yes No		Arm or leg pain	Yes No
Sore throats	Yes No		Joint pain or swelling	Yes No
			Arthritis	Yes No
<i>Neck</i>				
Neck Mass	Yes No		<i>Neurological</i>	
Neck Pain	Yes No		Fainting spells or "blackouts"	Yes No
Neck Stiffness	Yes No		Seizures	Yes No
Swollen Glands	Yes No		Problems with your memory	Yes No
			Disorientation	Yes No
<i>Respiratory</i>			Difficulty with your speech	Yes No
Chronic cough	Yes No		Double or blurred vision	Yes No
Shortness of breath	Yes No		Face weakness	Yes No
Pneumonia	Yes No		Loss of coordination	Yes No
Lung cancer	Yes No			
Bloody sputum	Yes No			

