NEW 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:		
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*

CLINICAL INFORMATION

Patient Information:			
Last Name:	First Name:	Middle:	Date of Birth:

Reason for Visit:	
Referred By:	Physician's #:
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) __	Neurological Disorder __
Heart Disease __	Kidney Disease __
Arthritis __	Glaucoma __
Diabetes __	Thyroid Disease __
Environmental Allergies __	Elevated Cholesterol __
Cancer (type): _____	Stroke __
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 _____	

Review of Systems: Do you experience any of the following? *check all that apply*			
Fever/Chills __	Dizziness / Imbalance __	Palpitations __	Headache __
Weight Loss __	Muscle Weakness __	Chest Pains __	Eye Problems __
Loss of Appetite __	Arthritis / Joint Pain __	Heartburn / Indigestion __	Frequent Urination __
Shortness of Breath __	Easy Bruising __	Depression __	Painful Urination __

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

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