THE NEW YORK OTOLARYNGOLOGY GROUP, P.C.

The Ear, Nose, and Throat Specialists

Patient Registration Form

Last Name: .	First Name: .	DOB:	SSN:
Reason For Visit:			
Referred By:		Ref Physician's Tel:	
Ref Physician's Address:			
Primary Care Physician:		Physician's Tel:	
Physician's Address:			

MEDICATIONS: (List all medications you are taking)	**ALLERGIES (To medications or substances)**
□ None	□ None

SOCIAL HISTORY

Do you smoke? □ Yes □ No Did you smoke? □ Yes □ No If Yes: □ Cigarettes □ Cigars □ Pipe

If you ever smoked, when did you stop? _____

Do you drink? □ Yes □ No If so, how many drinks per day? _____

Do you or have you ever used IV drugs? □ Yes □ No

PAST OR CURRENT MEDICAL ILLNESSES:

- □ Hypertension (high blood pressure)
- □ Lung Disease (COPD, Asthma)
- □ Heart Disease
- □ Arthritis
- □ Diabetes
- □ Environmental Allergies
- Cancer (type): _____
- □ Bleeding Disorder
- □ Neurological Disorder
- □ Kidney Disease
- □ Glaucoma
- □ Thyroid Disease
- □ Elevated Cholesterol
- □ Stroke

DO YOU HAVE A PACEMAKER? □ Yes □ No ANY PROBLEMS WITH HEARING? □ Yes □ No

HOSPITALIZATIONS/SURGERIES: Year	Reason	REASON for hospitalization/TYPE of surgery:

REVIEW OF SYSTEMS Do you experience any of the following:

□ Fever/Chills	□ Dizziness/Imbalance	□ Palpitations	□ Headache	□ Sinus Problems
□ 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:** _____

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* Indicates Field is required by the Dept. of Health and Human Services

Patient Name: ., .	DOB: Age:
Home Address:	Home Phone: □ Preferred
City/St/Zip:	Work Phone: □ Preferred
SSN#: Gender:	Cell Phone: □ Preferred
Occupation:	Email Address:
Preferred Language:	*Race:
*Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown □ Decline	
IS THE REASON FOR YOUR VISIT DUE TO: Auto Accident? □ Yes □ No Work Related? □ Yes □ No	**REASON FOR VISIT:**
Last NYOG Appt:	Next NYOG Appt:

Primary Insurance:	**Secondary Insurance:**
Policy Holder:	Policy Holder:
Policy #	Policy #:
Group #:	Group #:
Policy Holder DOB:	Policy Holder DOB:

Pharmacy Requirement Preferred Pharmacy:

Pharmacy Address: Pharmacy Phone:

Would you like to receive appointment reminders and notice of special events by email and text from NYOG?

□ YES □ NO

I understand that I am financially responsible for all fees for services rendered to me including the balance remaining after the possible insurance benefits. I hereby authorize the direct payment of services rendered to me and authorize the release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original.

Signature: □ Patient □ Guardian **Date:**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to NYOG for services furnished to me by the provider. authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: **Date:**