MONOCACY HEALTH PARTNERS
SURGICAL SPECIALISTS

MONOCACY HEALTH PARTNERS
OTOLARYNGOLOGY (EAR, NOSE, AND THROAT) CARE

We appreciate the value of your time. Here are some tips to help us provide comprehensive care in an efficient manner.

- Please bring your insurance card and photo ID with you.
- Payment is expected at time of service. We accept cash, check and all major credit cards.
- If you are a member of an HMO please contact your primary care physician to obtain a referral. Most offices require 48 hours' notice to issue a referral.
- For all new patients to our practice, please have appropriate records forwarded to our office prior to your appointment. Your Doctor's office will either mail or fax them to our office, but you must request them. This includes any recent office notes, labs or imaging. If your imagining was done outside of FMH please bring the disk with you so our doctors can review them.
- If there are any labs or testing that was ordered for this office visit, please have them done approximately 1 week prior to your appointment.
- Please arrive ***30 minutes*** early to **check in** and complete any paper work that may not be done. You may be asked to reschedule if you arrive after your **Check in time**.

We are working hard to ensure your time with us is as pleasant as possible. We are committed to your care and value any feedback you may have for us. Thank you and we look forward to seeing you!

Respectfully,

Your providers and staff at Surgical and ENT Specialists

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PATIENT REGISTRATION FORM

PATIENT

NAME (First, Middle, Last) | DATE OF BIRTH | BIRTH SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

STREET ADDRESS OR MAILING ADDRESS (PO BOX) | CELL PHONE NUMBER | PRIMARY PHONE NUMBER

CITY | STATE | ZIP CODE | E-MAIL (Required for Patient Portal) | WORK PHONE NUMBER

EMPLOYER | EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Active Duty | STUDENT STATUS ☐ Full Time ☐ Part Time ☐ Not Student

PRIMARY CARE PROVIDER | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Annulled ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Interlocutory ☐ Life Partner ☐ Polygamous ☐ Unknown | PREFERRED CONTACT METHOD (Check all that apply) ☐ Home Address(letters) ☐ Home Phone ☐ Cell Phone

PRIMARY LANGUAGE | SOCIAL SECURITY #

RACE ☐ American Indian/Alaskan Native ☐ White/Caucasian ☐ Black ☐ Multiracial ☐ Asian/Pacific Islander ☐ Refused/undetermined

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused or Undetermined

CURRENT GENDER ☐ Female ☐ Male ☐ Undifferentiated

PREFERRED PRONOUN ☐ Choose not to disclose ☐ Decline to Answer ☐ She, Her, Hers ☐ He, Him, His ☐ Ze, Hir ☐ They, Them, Theirs ☐ Other

SEXUAL ORIENTATION ☐ Choose not to disclose ☐ Straight or Heterosexual ☐ Bisexual ☐ Don't Know ☐ Lesbian, gay or homosexual ☐ Something else, please describe

GENDER IDENTITY ☐ Choose not to disclose ☐ Additional gender category or other, please specify ☐ Female ☐ Female-to-Male(FTM)/Transgender Male/Trans Man ☐ Genderqueer, neither exclusively Male nor Female ☐ Male ☐ Male-to-Female(MTF)/Transgender Female/Trans Woman

RESPONSIBLE PARTY

NAME (First, Middle, Last) | DATE OF BIRTH | SEX ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

ADDRESS | TELEPHONE – HOME | TELEPHONE - WORK

RELATIONSHIP TO PATIENT ☐ Parent ☐ Guardian ☐ Other | EMPLOYER

PRIMARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID# ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____ Birthdate_____

ADDRESS _____ Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP ☐Self ☐Spouse ☐Dependent ☐Other

SECONDARY INSURANCE CARRIER

INSURANCE CARRIER NAME-

INSURANCE ID # ***See card*** GROUP # ***See card***

SUBSCRIBER (POLICY HOLDER)

NAME _____Birthdate_____

ADDRESS _____Phone_____

PATIENT-SUBSCRIBER RELATIONSHIP ☐Self ☐Spouse ☐Dependent ☐Other

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME | DAYTIME TELEPHONE | EVENING TELEPHONE

If you are here for an injury, is it: ☐ Work Related ☐ Auto Related ☐Neither

ALL PAYMENT DUE AT TIME OF SERVICE

I authorize payment of insurance benefits directly to Monocacy Health Partners. I will be responsible for fees and charges according to Monocacy Health Partners and my health plan. If I do not provide a VALID insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Monocacy Health Partners and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages, and/or an automatic dialing device ("auto dialer"), by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

Patient Signature: _____ Date: _____

Or

Patient Representative_____ Relationship to Patient: _____

MONOCACY HEALTH PARTNERS SURGICAL SPECIALISTS

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Health Insurance Portability and Accountability Act (HIPAA) Form

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Monocacy Health Partners, have been offered a copy of the Notice of Privacy Practice which describes my privacy rights in accordance to federal and state requirements.

_____ _____

Signature of Patient or Authorized Representative Date

Communication Consent

"I understand that I may be contacted by Frederick Regional Health System/Monocacy Health Partners and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: _____. This communication is to confirm office appointments or leave a message regarding my care.

☐ ***No***, please ***do not*** contact me by the following means: _____

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is the patient's responsibility to notify Monocacy Health Partners of any changes to this form.

_____ _____

Print Patient's Name Home/Cell Phone Number (Please circle)

_____

Patient's Date of Birth

_____ _____

Patient or Legally Responsible Person's Signature Date Witness Date

Rev. 6/1/18

Office Use Only

Entered by: _____ Date: _____

MONOCACY HEALTH PARTNERS SURGICAL SPECIALISTS

MONOCACY HEALTH PARTNERS OTOLARYNGOLOGY (EAR, NOSE, AND THROAT) CARE

SURGICAL SPECIALISTS-ENT PATIENT HEALTH HISTORY

Today's Date: _____

Name: _____

DOB: _____Occupation: _____Primary Care Physician:_____

Reason for visit:_____Temp:_____Pulse:_____Resp:_____

Preferred Pharmacy: _____

REVIEW OF SYSTEMS

NUMERICAL PAIN SCALE

Circle a number from 0 to 10 that best describes how much pain you are having right now.

No Pain -0 1 2 3 4 5 6 7 8 9 10 -Worst Possible Pain

1. Have you ever had any of the following medical conditions? (Please choose NO or YES for every item)

CONSTITUTIONAL

No Yes
- ☐ ☐ Chills
- ☐ ☐ Change in appetite
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss

HEENT

No Yes
- ☐ ☐ Double vision
- ☐ ☐ Pain
- ☐ ☐ Other: _____
- ☐ ☐ Sinus problems
- ☐ ☐ Deafness
- ☐ ☐ Other: _____

RESPIRATORY

No Yes
- ☐ ☐ Cough
- ☐ ☐ Wheezing
- ☐ ☐ Dyspnea (Shortness of Breath
- ☐ ☐ Asthma
- ☐ ☐ Sleep Apnea
- ☐ ☐ Do you use a CPAP or BIPAP?

Other: _____

CARDIOVASCULAR

No Yes
- ☐ ☐ Chest pain
- ☐ ☐ Heart attack/MI
- ☐ ☐ Irregular heartbeat
- ☐ ☐ High blood pressure
- ☐ ☐ High cholesterol
- ☐ ☐ Pacemaker?
- ☐ ☐ Have you had stents inserted?

Other: _____

GASTROINTESTINAL

No Yes
- ☐ ☐ Abdominal pain
- ☐ ☐ Indigestion/heartburn
- ☐ ☐ Constipation
- ☐ ☐ Hepatitis
- ☐ ☐ Colitis/Enteritis
- ☐ ☐ Nausea
- ☐ ☐ Diarrhea
- ☐ ☐ Vomiting
- ☐ ☐ Hemorrhoids
- ☐ ☐ Rectal bleeding

Other: _____

GENITOURINARY

No Yes
- ☐ ☐ Urinary retention
- ☐ ☐ Urinary infection
- ☐ ☐ Kidney stones
- ☐ ☐ Prostatitis
- ☐ ☐ Frequency/urgency
- ☐ ☐ Painful urination

Other: _____

ENDOCRINE

No Yes
- ☐ ☐ Excess thirst
- ☐ ☐ Too hot/cold
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disorder
- ☐ ☐ Tired/sluggish

Other: _____

NEUROLOGICAL

No Yes
- ☐ ☐ Stroke
- ☐ ☐ Dizziness
- ☐ ☐ Migraines
- ☐ ☐ TIA
- ☐ ☐ Seizure
- ☐ ☐ Tremors

Other: _____

PSYCHIATRIC/PSYCHOLOGIC

No Yes
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Drug/alcohol abuse

Other: _____

IMMUNOLOGICAL

No Yes
- ☐ ☐ Hay fever
- ☐ ☐ Gout
- ☐ ☐ HIV/AIDS

Other: _____

INTEGUMENTARY

No Yes
- ☐ ☐ Skin rash
- ☐ ☐ Suspicious skin lesion

Other: _____

MUSCULOSKELETAL

No Yes
- ☐ ☐ Joint pain
- ☐ ☐ Neck pain
- ☐ ☐ Back pain
- ☐ ☐ Arthritis

Other: _____

HEMATOLOGIC/LYMPHATIC

No Yes
- ☐ ☐ Swollen glands
- ☐ ☐ Blood clots
- ☐ ☐ Bleeding disorder
- ☐ ☐ Lymphoma/leukemia

Other: _____

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Name: _____ **DOB:** _____

CANCER HISTORY

2. Have you ever been diagnosed with any type of cancer? ☐ NO ☐ YES *If you answered "YES", please list the type(s) of cancer:*

   Cancer: _____ Year: _____

   Cancer: _____ Year: _____

PAST MEDICAL HISTORY

3. Have you ever had surgery before? ☐ NO ☐ YES *If you answered "YES", please list prior operations below:*

   Cholecystectomy: ☐ NO ☐ YES Year: _____ Other Surgeries:
   Appendectomy: ☐ NO ☐ YES Year: _____
   Hernia: ☐ NO ☐ YES Year: _____ Operation:_____ Year: _____
   Type: _____
   Tonsillectomy: ☐ NO ☐ YES Year: _____ Operation:_____ Year: _____
   Cesarean Section: ☐ NO ☐ YES Year: _____ Operation:_____ Year: _____
   Coronary Bypass: ☐ NO ☐ YES Year: _____

   ANY COMPLICATIONS? (e.g., excessive bleeding, blood clots) _____

4. Please list any other know medical conditions:

   _____

   _____

   _____

MEDICATION HISTORY

5. Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements and over-the-counter medications

MEDICATION	DOSAGE/FREQUENCY

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Name: _____ **DOB:** _____

FAMILY HISTORY

6. Have any of your parents and/or siblings had cancer? ☐ NO ☐ YES *If you answered "YES", please list the type(s) of cancer below:*

   Type: _____ Type: _____ Type: _____ Type: _____

7. Current marital status ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Living with partner ☐ Widowed

8. Children? ☐ NO ☐ YES *If "YES", please list their ages* _____ _____ _____ _____ _____ _____

9. Alcohol Use: ☐ None ☐ Rarely (social) ☐ Often ☐ Quit, if so, when: _____

SOCIAL HISTORY

10. Tobacco Use:

    Present:
    Currently smokes cigarettes regularly (at least one a day)? ☐ NO ☐ YES
    Currently on average, how many cigarettes do you smoke per day? (one pack=20) #cigarettes_____

    Past:
    In the past, have you ever smoked cigarettes regularly (at least 100 cigarettes)? ☐ NO ☐ YES
    How many years have you smoked cigarettes regularly (at least once a day)? _____years
    In the past, on average, how many cigarettes did you smoke per day (one pack=20) #cigarettes_____
    If you have quit smoking, what year did you quit? _____
    Do you currently smoke cigars? ☐ NO ☐ YES
    Do you use a pipe? ☐ NO ☐ YES

11. Drug Use: ☐ NO ☐ YES *If you answered "YES", what type(s)?* _____

ALLERGIES

12. Allergies: List all allergies, including latex, food, medications or contrast agents (IVP, CT dye, etc.).

    A. _____ C. _____

    B. _____ D. _____

    ☐ **CHECK IF NO KNOWN ALLERGIES**

ADDITIONAL NOTES:

_____

_____

_____

Patient Signature: _____ Date: _____

Or Designee Signature: _____ Date: _____

Reviewed by: _____ Date: _____