

Account #: _____

Lakeside ENT Patient Registration

Date: _____

Patient Name: _____

Patient Demographic Information:

Date of Birth: _____

Age: _____

SSN: _____

Home Phone: _____

Work/Alternate Phone: _____

Address: _____

Primary Care: _____

Financially Responsible Party (Complete ONLY if different from patient):

Guarantor Name: _____

Date Of Birth: _____

SSN: _____

Relation to Patient: Spouse _____

Parent _____

Other (Please Specify) _____

Home Phone: _____

Work/Alternate Phone: _____

Address: _____

What is the reason for your visit?

Is this a new problem? YES NO

Women: Are you, or could you be, pregnant? YES NO

Is your visit due to a job or motor vehicle related injury? YES NO

If YES, please notify the receptionist.

Allergies: Please list any dyes, food, contact, environmental substances, or medications which have caused a reaction.

1) _____

4) _____

7) _____

2) _____

5) _____

8) _____

3) _____

6) _____

9) _____

Are you allergic to latex? YES NO

Medications: Please list any prescription medications, over the counter medications, vitamins, herbs, or nutritional supplements you are currently taking. Please include dosage and the times a day you take them.

Medication

Dosage

Medication

Dosage

1) _____

6) _____

2) _____

7) _____

3) _____

8) _____

4) _____

9) _____

5) _____

10) _____

Medical/Surgical History:

Illness or Operation

Date

Illness or Operation

Date

Do you currently smoke? YES NO

If yes, how much?

How many years?

Did you smoke in the past? YES NO

If yes, when did you quit?

Do you drink alcohol? YES NO

If yes, how much per week?

Do you use recreational/illegal drugs? YES NO

What is your current or most recent occupation?

Is there anything else we should know about you to provide optimum care?