Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Name	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

I have received a copy of Maurice Khosh MD , PC Notice of Privacy Practices. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or test performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visit is expected at the time of service.

_____ _____

Signature of Patient or Authorized Guardian **Date**

Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Current Medications

Are you currently taking any blood thinners? ☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Do you have any other allergies?

Name	Reaction
Name	Reaction
Name	Reaction

ENT

Do you have any of the following?

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Clicking in Ears
- ☐ Crossed Eyes
- ☐ Decreased Sense of Smell
- ☐ Decreased Sense of Taste
- ☐ Difficulty Breathing
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Facial Paralysis
- ☐ Hay Fever
- ☐ Hoarsness
- ☐ Hearing Loss
- ☐ Itching in Ears
- ☐ Lumps / Knots in Neck
- ☐ Nasal Obstruction
- ☐ Neck Pain
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Throat Pain
- ☐ Vision Halos

Past Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Family History

Details:

Health Information

Your Height _____ Your Weight _____