FAYETTEVILLE OTOLARYNGOLOGY
Advanced Hearing Services • Allergy • Ear, Nose & Throat
Surgery • Facial Plastics & Reconstructive Surgery

1839 Quiet Cove
Fayetteville, NC 28304
(910) 323-1463

Patient Registration

Have you ever seen a physician in this practice? Y/N _____ Who? _____ How did you hear about us? _____

Date? MM DD YYYY Patient _____ Date of birth MM DD YYYY

Mailing address _____ City _____ State NC ZIP _____

Sex - M/F _____ Race _____ Marital status -S/M/D _____ Language _____ SS# ###-##-####

Ethnicity (check one): _____ NOT Hispanic / Latino _____ Hispanic / Latino Pharmacy _____

Home telephone (###) ###-#### Work / Other telephone (###) ###-#### Cell (###) ###-####

May we leave confidential messages on your home/cell answer machine if you are not available? Yes or No _____

Occupation (of parent if a minor) _____ Employer _____

Responsible party name _____ Relationship to patient _____ DOB MM DD YYYY SS# ###-##-####

Emergency contact _____ Telephone (###) ###-####

Primary insurance _____ Secondary insurance _____

Referring/Medical physician _____ Chief complaint _____

Current medication/dose _____

_____

Allergies to medications _____

Tobacco use? Y / N _____ What? _____ Alcohol use? Y / N _____

Have you or a family member had any anesthesia problems? Y / N _____

List any surgical procedures & dates _____

_____

Please indicate past medical history for you and your family (check all that apply).

Patient/Family		Patient/Family		Patient/Family	
____/____	High Blood Preassure	____/____	Emphysema	____/____	Arthritis
____/____	Stroke	____/____	HIV	____/____	Gout
____/____	Heart Disease	____/____	TB	____/____	Acid Reflux
____/____	Diabetes	____/____	Syphilis	____/____	Hearing Loss
____/____	Kidney Problems	____/____	Bleeding Disorder	____/____	Ear infections
____/____	Liver Problems	____/____	Anemia	____/____	Sinusitis
____/____	Thyroid Problems	____/____	Transfusions	____/____	Nasal Polyps
____/____	Depression, Anxiety	____/____	Nose Bleeds	____/____	Tonsillitis
____/____	Seizure	____/____	Weight Loss	____/____	Croup
____/____	ADD/Attention Deficit Disorder	____/____	Cancer _____	____/____	Scarlet Fever
____/____	Head Injury	____/____	Vision Problems	____/____	Rheumatic Fever
____/____	Asthma	____/____	Glaucoma	____/____	Hay Fever / Allergies

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Your insurance contract is an agreement between you and your insurance company. As a service to you, we will be glad to file the appropriate forms with your insurance company. You are responsible for any deductibles, co-pays, co-insurance and non-covered services today. I hereby consent to treatment and further authorize Fayetteville Otolaryngology to disclose information in my medical record to other physicians and health care providers to whom Fayetteville Otolaryngology may refer me. I request payment of authorized benefits to be made on my behalf to Fayetteville Otolaryngology. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct.

Signature of patient (parent/guardian) _____ Date MM/DD/YYYY