

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

Allergies

Do you have any other allergies?

Name	Reaction

ENT

Do you have any of the following?

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

Past Medical History

Have you ever had any of the following?

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

Hospitalizations & Surgeries

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 _____