PATIENT REGISTRATION FORM

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Preferred name/nickname:
Address:		City/State/Zip:	
Mailing address (if different):			
Home Phone:	Cell Phone:	Work Phone w/ext.	
Preferred method of communication: Voice / Text / Email / Other:		Preferred Phone: Home / Cell / Work / Other:	
Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner		Employer:	
Date of Birth:	Soc. Sec. #:	Email address:	
Emergency Contact:	Phone:	Relationship to Patient:	

Responsible Party

Person responsible for the bill (Only if patient is a minor child): Last Name: First Name: M.I.:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Phone:
Address:	City/State/Zip:	
Employer:		

Insurance & Payment Info

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Insurance ID #:	Insurance ID #:
Policy Holders Name:	Policy Holders Name:
Effective Date:	Effective Date:
Policy Holders SSN:	Policy Holders SSN:
Relationship to Patient:	Relationship to Patient:
Employer Name	Employer Name

Other Information

Can we leave messages regarding your medical care, test results and financial obligations or business office needs?: ☐ No ☐ Yes. If yes: ☐ Home ☐ Work ☐ Cell
Race (please select one): ☐ Caucasian or White ☐ Native American or Alaska Native ☐ Asian ☐ Black of African-American ☐ Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Other Race ☐ Decline
Ethnicity (please select one): ☐ Hispanic ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other:
Preferred Pharmacy Name & Location:
Family or Primary Care Provider(s):

I certify that the information I have furnished is complete and accurate. I hereby authorized payment of benefits payable under my insurance plan and/or of any government payment plan be paid directly to West River Ear, Nose, and Throat, which I agree will be credited to my account. I authorize assignee to obtain my plan provisions under ERISA and to act as authorized representative on my behalf on insurance claims. A photocopy of this assignment is to be considered as valid as the original. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I understand that I will be responsible to West River Ear, Nose, and Throat for all amounts including those not paid by my insurance payer due to their payment rules or guidelines. I hereby give my consent for West River Ear, Nose, and Throat to use and disclose my protected health information for the purposes of treatment, payment and health-care operations.

Signed: ______________________________ **Date:** ____________________

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices outlines our obligations to you under federal privacy law. We are obligated to provide you with a copy of our Notice at the time of your appointment. **In addition, we ask you to let us know to whom you will allow access to your medical records, account and/or billing information.** The phone number(s) and address you provide us will be used to contact you for appointment reminders, medical follow-up, questions regarding account information, billing and insurance claims questions, mailing account statements and other contacts unless you tell us otherwise. We may ask you to complete an authorization for release of medical information if there are any questions or concerns.

I acknowledge that I have received a copy of West River Ear, Nose and Throat's Notice of Privacy Practices.

Patient/Responsible Party Signature____ **Date** ______________________

❑ Attempt made to obtain acknowledgement of receipt of Notice of Privacy Practices however the patient either refused to sign or other: _____
____

Please list the name(s) of family, friends or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing and insurance questions, etc.:

Name	Relationship	E-mail address	Phone #

CONSENT FOR CARE OF MINOR

Children under the age of 14 must be accompanied by an adult for any appointment.

As the Parent or guardian to ___________________________________, Age __________, a minor, I authorize the following:

____ I authorize _________________________, to be seen at West River Ear, Nose, and Throat with a parent or guardian present.
Initials

____ I authorize _________________________, to be seen and treated at West River Ear, Nose, and Throat when accompanied only by the
initials following adult, friend, child care provider or other:

Name	Relationship

This consent shall remain in full force and effect until revoked by me or the minor attains eighteen (18) years of age.

____ ______________________________
Parent or Guardian Date

PATIENT HISTORY QUESTIONNAIRE

Please complete this questionnaire and bring it with you to your appointment.

Name: ____Date of Birth: ____________________ Age: ________

Referring Provider: ____ Height: ____________ Weight: ____________

CHIEF COMPLAINT:

What medical problems would you like us to assist you with today?

____

____

____

____

PAST MEDICAL HISTORY

Do you have or ever had any of the following?

	Yes	No		Yes	No
Heart Disease or Heart Attack			Gastrointestinal Disorders		
High Blood Pressure			Asthma		
Cancer			Kidney Disease		
Bleeding Problems			Diabetes		
Depression/Anxiety			Liver Disease		
Arthritis			Rheumatic Fever		
Heart Murmur			Tuberculosis		
Other:					

PAST SURGICAL HISTORY

Please list any surgical procedures you have had.

Procedure	Date	Surgeon

Please continue on the back side.

Please list any drug allergies you have: ____

____

FAMILY HISTORY

Does anyone in your family have a history of any of the following?

	Yes (if yes-then who)	**no**		**yes (if yes-then who)**	**No**
Heart Disease			Kidney Disease		
High Blood Pressure			Diabetes		
Lung Disease			Bleeding Disorders		
Cancer			Other:		

SOCIAL HISTORY

	yes	**no**	**if yes, how much?**
Do you smoke?			
Are you exposed to passive smoke?			
Do you drink alcohol?			
Recent weight change?			

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ❑ **None**

Medication	**Dosage**	**How often taken**

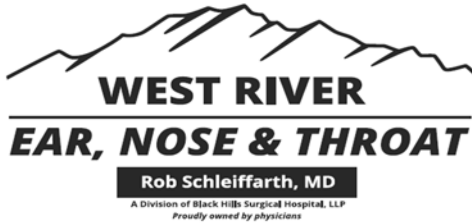
Medication	**Dosage**	**How often taken**

Cardiovascular:
Coronary Artery Disease ❑ **Yes**
Elevated cholesterol (hyperlipidemia) ❑ **Yes**
High Blood Pressure (hypertension) ❑ **Yes**
Gastrointestinal:
Hepatitis ❑ **Yes**
Hernia ❑ **Yes**
Gastroesophageal Refulx ❑ **Yes**
Genitourinary:
Prostate enlargement (Prostatitis) ❑ **Yes**
Kidney Stones (Nephrolithiasis) ❑ **Yes**
Acute Renal Failure ❑ **Yes**
Ear / Nose / Throat: (HEENT)
Cataracts ❑ **Yes**
Glaucoma ❑ **Yes**
Chronic ear infections (otitis media) ❑ **Yes**
Hearing loss ❑ **Yes**
Sinus problems (chronic sinusitis) ❑ **Yes**
Nasal polyps ❑ **Yes**
Nasal Allergies ❑ **Yes**
Recurrent tonsillitis ❑ **Yes**
Tinnitus ❑ **Yes**
Vertigo ❑ **Yes**
Hematologic:
Anemia ❑ **Yes**
Immunologic:
Allergies Type:_________ ❑ **Yes**
Food allergies Type:_________ ❑ **Yes**
HIV / AIDS ❑ **Yes**
Infectious Disease:
Mononucleosis ❑ **Yes**
STD Type:_________________ ❑ **Yes**
Metabolic/endocrine:
Diabetes Type:_______________ ❑ **Yes**
Thyroid deficiency (hypothyroidism) ❑ **Yes**
Thyroid excess (hyperthyroidism) ❑ **Yes**
Neoplastic:
Cancer Type:________________ ❑ **Yes**
Neurologic:
Migraine ❑ **Yes**
Obstetric:
Pregnancy Date(s):____________ ❑ **Yes**
Psychiatric:
Adjustment Disorder – Anxiety ❑ **Yes**
Major Depression ❑ **Yes**
Pulmonary:
Asthma ❑ **Yes**
COPD/Emphysema ❑ **Yes**
SleepApnea ❑ **Yes**
Tuberculosis ❑ **Yes**
Miscellaneous:
Anesthesia Reaction ❑ **Yes**
Miscellaneous PEDIATRIC ❑ **Yes**
Complications during Pregnancy ❑ **Yes**
Complications during Delivery ❑ **Yes**
NICU stay >48hrs:____________ ❑ **Yes**
Preterm birth ❑ **Yes**

SIGNATURE: ____ **DATE:** _____________________

THANK YOU

Reviewed by:________________________________



DISCLOSURE OF PHYSICIAN OWNERSHIP FORM
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Your Physician at this clinic is an owner of Black Hills Surgical Hospital, LLP (BHSH) which includes its medical imaging division Black Hills Imaging Center (BHIC). Additionally, if you choose to receive treatment at BHSH or BHIC, other physicians there may provide you treatment who may have ownership in BHSH. For your reference, following is a list of all physician owners or investors in BHSH.

    Angela K. Anderson, MD
    Trevor Anderson, MD
    Mark Ballard, MD
    Jeffrey L. Bendt, MD
    Gail Bernard, MD
    Marcia Beshara, MD
    Margaret Chilvers, MD
    Christopher Dietrich, MD
    Clark Duchene, MD
    Aaron Dykstra, MD
    Stephen Eckrich, MD
    David Fromm, MD
    Stuart Fromm, MD
    Steven Giuseffi, MD
    Robert Q. Ingraham, MD
    Michael Kadrmas, MD
    Jason LaBrie, MD
    David Lang, MD
    Brett Lawlor, MD
    Jeffrey Marrs, MD
    Emmett McEleney, MD
    Lew Papendick, MD
    Kent Renaud, DPM
    Stuart Rice, MD
    Jennifer Ryder, DPM
    Jack Robert Schleiffarth, MD
    Rand Schleusener, MD
    Pamela Schmagel, MD
    Neil E. Skea, DPM
    Mary Snyder, MD
    Lee Trotter, DO
    Peter E. Vonderau, MD
    Tim Watt, MD
    Jonathan L. Wilson, MD
    Robert Woodruff, MD

2. You have the right to choose the provider of your healthcare service. Therefore, you have the option to use a healthcare facility other than BHSH or its medical imaging division BHIC.

3. If you have any questions concerning this notice, please feel free to ask your Physician, any representative of our office, BHSH or BHIC. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read the foregoing notice and you hereby select BHSH and/or BHIC to provide those surgery or related healthcare services prescribed by your Physician.

____
Name of Patient

____
Signature of Patient

____
Name of Parent or Guardian (if applicable)

____
Signature of Parent or Guardian (if applicable)

____
Date