MEDICAL GROUP

Patient Registration Form

TODAY'S DATE	DEPARTMENT.
(Please Print)	MRN

PATIENT INFORMATION

PATIENT'S NAME: (LAST) (FIRST) MIDDLE	AGE:	SEX:	BIRTH DATE:	MARITAL STATUS (CIRCLE ONE) Single / Mar / Div / Sep / Wid

SOCIAL SECURITY #.:	RACE:	ETHNICITY:	LANGUAGE:

STREET ADDRESS:	APT #:	CITY/ STATE:	ZIP CODE:

HOME PHONE #:	CELL PHONE #.	EMAIL:	COUNTRY:

EMPLOYER:	EMPLOYER ADDRESS:	EMP. CITY/ STATE:	EMP. ZIP CODE:

EMPLOYER PHONE #:	NEXT OF KIN:	NEXT OF KIN PHONE #:	RELATIONSHIP:

PRIMARY CARE PHYSICIAN:	PRIMARY CARE PHYSICIAN PHONE #:

REFERRING PHYSICIAN:	REFERRING PHYSICIAN ADDRESS:	REF. CITY/STATE:	REF. ZIP CODE:

RESPONSIBLE PARTY INFORMATION

GUARANTOR NAME:	ADDRESS (IF DIFFERENT)	CITY/ STATE.	ZIP CODE:

PHONE #:	EMPLOYER:	EMP. PHONE #:

EMPLOYER ADDRESS:	EMP. CITY/ STATE:	EMP. ZIP CODE:

WAS AN INJURY INVOLVED? ☐ Yes ☐ No	IF YES > DATE OF INJURY:	TIME OF INJURY:	WAS IT WORK RELATED?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

NAME OF PRIMARY INSURANCE:	SUBSCRIBER'S NAME:

RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?

SUBSCRIBER STREET ADDRESS:	APT #:	CITY/ STATE:	ZIP CODE:

ID #:	GROUP #:	PLAN #:

(SECONDARY INSURANCE INFORMATION)

NAME OF SECONDARY INSURANCE (IF APPLICABLE):	SUBSCRIBER'S NAME.

RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?

SUBSCRIBER STREET ADDRESS:	APT #:	CITY/ STATE:	ZIP CODE:

ID #:	GROUP #	PLAN #

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: VIRGINIA LAW (VIRGINIA CODE SECTION 32.1-45.1) PROVIDERS THAT WHEN EITHER A PERSON PROVIDING HEALTH CARE SERVICE OR A PATIENT IS DIRECTLY EXPOSED TO THE BODY FLUIDS OF THE OTHER IN A WAY THAT MAY TRANSMIT HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) OR HEPATITIS B OR C VIRUS, SUCH OTHER PERSON IS DEEMED TO HAVE CONSENTED TO TESTING FOR THOSE VIRUSES AND TO RELEASE OF THE TEST RESULTS TO THE PERSON SO EXPOSED, AND ACTUAL CONSENT IS NOT REQUIRED.

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE ANY MEMBER OF EASTERN VIRGINIA MEDICAL SCHOOL MEDICAL GROUP (EVMS MEDICAL GROUP) AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COSTS, 25% ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY EVMS MEDICAL GROUP AND A $20 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE EVMS MEDICAL GROUP MY PERMISSION TO ALLOW VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

FOR HEALTH CARE OPERATIONS: WE MAY DISCLOSE YOUR MEDICAL INFORMATION IN ORDER TO OPERATE THE EVMS MEDICAL GROUP PRACTICE PLAN. FOR EXAMPLE, WE MAY USE YOUR MEDICAL INFORMATION IN ORDER TO EVALUATE THE QUALITY OF HEALTH CARE SERVICES, TO EVALUATE THE PERFORMANCE OF THE HEALTH CARE PROFESSIONALS, AND TEACHING AND TRAINING OF HEALTH CARE PERSONNEL. WE MAY ALSO PROVIDE YOUR MEDICAL INFORMATION TO OUR ACCOUNTANTS, ATTORNEYS, CONSULTANTS, AND OTHERS IN ORDER TO MAKE SURE WE'RE COMPLYING WITH THE LAWS THAT AFFECT US.

NOTICE OF PRIVACY PRACTICES: I HAVE RECEIVED (HAVE BEEN OFFERED) THE EVMS MEDICAL GROUP PRIVACY NOTICE WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY EVMS MEDICAL GROUP AND ITS AFFILIATES

PATIENT NAME (PRINT) PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE

WITNESS SIGNATURE DATE

EASTERN VIRGINIA MEDICAL SCHOOL
DEPARTMENT OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY
EVMS HEARING AND BALANCE CENTER

MAIN OFFICE:
RIVER PAVILION, SENTARA NORFOLK GENERAL HOSPITAL
600 Gresham Drive, Suite 1100, Norfolk, Virginia 23507-1904
(757) 388-6200
www.evmsent.org

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, ____________________________________ (print name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

____

(Print Name of Personal Representative)

This person is to be afforded all of the privileges that would be afforded to me with respect to my health information, unless I have specifically made restrictions to the following functions as noted below:

____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Department of Otolaryngology - Head and Neck Surgery. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

______________________________ ______________________________

Patient Signature Date

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

______________________________ ______________________________

Patient Signature Date

EVMS HEARING AND BALANCE CENTER HEARING AND BALANCE HISTORY

Patient Name ______________________________ Date____________ DOB__ _________

Hearing:

1. Do you have any hearing problems? ❑ No ❑ Yes ❑ Right ear ❑ Left ear
2. Has your hearing loss been? ❑ Gradual ❑ Sudden ❑ Fluctuating
3. How long have you had a hearing problem? ______________________________
4. Does anyone in your family have hearing loss? ❑ No ❑ Yes Who? ____________
5. Do you own hearing aids? ❑ No ❑ Yes ❑ Right ear ❑ Left ear
6. Do you have fullness or pressure in your ears? ❑ No ❑ Yes
7. Have you been exposed to loud noise? ❑ No ❑ Yes When? ________________
8. Do you have a history of ear infections? ❑ No ❑ Yes

Tinnitus (Head noise):

1. Do you have noise in your ears or head? ❑ No ❑ Yes ❑ Right ear ❑ Left ear
2. If yes, is the noise: ❑ Constant ❑ Periodic ❑ Pulsating ❑ Low pitch ❑ High pitch

Dizziness:

1. Do you have dizziness, vertigo, or unsteadiness? ❑ No ❑ Yes
2. **Choose only one** of the following as to which one **BEST** describes your dizziness:
   - ❑ A sensation of movement of the room: spinning, tilting, or wave-like movement
   - ❑ Lightheadedness or feeling that you are going to faint
   - ❑ Loss of balance
   - ❑ Disassociation, disorientation, or loss of attachment with the world
3. When did the dizziness first occur?______________________________________
4. Is the dizziness? ❑ Constant, all day long more or less ❑ In episodes or attacks
5. If the dizziness comes in attacks, how often do the attacks occur? ________________

   ____
6. If the dizziness comes in attacks, how long do the attacks last? __________________

   ____
7. When you are "dizzy" do you experience any of the following sensations? **You may check as many yes responses as necessary.**
   - ❑ No ❑ Yes 1. Blacking out or loss of consciousness.
   - ❑ No ❑ Yes 3. Objects or the room spinning?
   - ❑ No ❑ Yes 4. Sensation that you are turning or spinning inside?
   - ❑ No ❑ Yes 5. Loss of balance when walking?

MD Initials______________

EVMS HEARING AND BALANCE CENTER HEARING AND BALANCE HISTORY

Patient Name ______________________________ Date____________ DOB__ ________

- ❑ No ❑ Yes 6. Lightheadedness or giddiness?
- ❑ No ❑ Yes 7. Headache or Pressure in the head?
- ❑ No ❑ Yes 8. Have you ever fallen because of your dizziness?
- ❑ No ❑ Yes 9. Nausea or vomiting?
- ❑ No ❑ Yes 10. Changes in vision, flashes of light, double vision, blind spots?
- ❑ No ❑ Yes 11. Numbness or weakness in the arms or legs, or changes in speech?
- ❑ No ❑ Yes 12. Pain or tightness in the neck

8. What factors provoke the dizziness or make the dizziness worse? ❑Driving ❑Looking up ❑Getting up quickly ❑Rolling over in bed ❑ Turning my head ❑Activity ❑ Stress ❑ Other ______________
____
9. Does your hearing change when the dizziness occurs? ❑ No ❑ Yes ❑ Right ear ❑ Left ear
10. Do you have a change in head noise during the spells? ❑ No ❑ Yes ❑ Right ear ❑ Left ear
11. Do you have pressure or fullness in your ears during the spells? ❑ No ❑ Yes ❑ Right ❑ Left
12. Are you completely free of dizziness between attacks? ❑ No ❑ Yes

Neurologic History:

1. ❑ No ❑ Yes Have you ever been diagnosed with a head or neck injury?
2. ❑ No ❑ Yes Do you or anyone in your family have a history of migraine?
3. ❑ No ❑ Yes Have you ever had a seizure, multiple sclerosis, mini-stroke or stroke?
4. Have you experienced any of the following symptoms?
   - ❑ No ❑ Yes 1. Double vision, blurred vision or blindness
   - ❑ No ❑ Yes 2. Numbness or weakness of face, arms or legs
   - ❑ No ❑ Yes 5. Unusual clumsiness
   - ❑ No ❑ Yes 6. Confusion or loss of consciousness
   - ❑ No ❑ Yes 7. Difficulty with speech or swallowing
   - ❑ No ❑ Yes 9. Pain in the neck or shoulder

3. Have you recently had any of the following?
   - ❑ No ❑ Yes 1. Hearing test?
   - ❑ No ❑ Yes 2. MRI or CT of the head or neck?
   - ❑ No ❑ Yes 3. Balance Testing?
   - ❑ No ❑ Yes 4. Lumbar puncture to test spinal fluid?
   - ❑ No ❑ Yes 5. Blood tests for dizziness
   - ❑ No ❑ Yes 6. Evaluation by a neurologist?
   - ❑ No ❑ Yes 7. Evaluation by an ear doctor?
   - ❑ No ❑ Yes 8. EEG (brain wave test)
   - ❑ No ❑ Yes 9. Heart Evaluation (EKG, Holter monitor, ECHO, Stress test, other)
   - ❑ No ❑ Yes 10. Carotid Doppler study (test of blood flow in neck)

MD Initials______________

EVMS HEARING AND BALANCE CENTER GENERAL HEALTH HISTORY

Patient Name ______________________ Date ______________ Chart # ________________

Age ___________ Date of Birth ______________ Reason for visit ______________________________

Race ___________ Sex (circle): Male Female Marital Status (circle) Single Married Widowed

Primary Care Physician ______________________ Referring Physician ______________________

Other treating Physicians ____

Medications

List all medications that you are taking including vitamins and over the counter medicines

Name	Strength (for example 5mg)	How often?	Condition being treated

Do you have any allergies to medicines? ☐ No ☐ Yes

Please list ____

Do you have any allergies to mold, dander, or other environmental agent? Please list ________________

Do you have any food allergies? Please list ______________________________

Social History

Occupation ______________________ Retired ☐ No ☐ Yes

Tobacco:
- None ____________
- Chew ____________
- Smoke ____________
- <1 pack/day ____________
- >1 pack/day ____________

Alcohol:
- None ____________
- Rare ____________
- 1-3 drinks/wk ____________
- 1-3 drinks/day ____________
- >3 drinks/day ____________

Drugs:
- None ____________
- Marijuana ____________
- Other ____________

Diet:
- Salty foods ____________
- Caffeine ____________

Are you or could you be pregnant? ☐ No ☐ Yes

MD Initials ________________

EVMS HEARING AND BALANCE CENTER GENERAL HEALTH HISTORY

Patient Name ______________________ Date____________ Chart # ______________

Medical History

Have you or any of your family members ever had any of the following? Check all that apply...

Condition	I have had/do have	My family member has had/does have	Family Member
Acid Reflux			
Allergy			
Anemia			
Angina or Heart Attack			
Arrythmia (abnormal heart beat)			
Arthritis			
Asthma			
Bleeding problems			
Cancer			
Chronic Bronchitis			
Diabetes			
Emphysema			
Head Injury			
Heart Failure			
Heart Murmur			
Hepatitis or Liver problems			
High Blood Pressure			
Intestinal Problems			
Kidney disease			
Leukemia/Lymphoma			
Migraine			
Psychiatric problems			
Reproductive problems			
Seizure disorder			
Stroke			
Thyroid disorder			
Tuberculosis			
Urinary Problems			
Vascular disease			

Surgical History

List all of your surgeries

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If yes, please list what sort of problems. ______________________________

Hospitalizations

Please list any hospitalizations

Date	Reason

MD Initials________________

EVMS HEARING AND BALANCE CENTER GENERAL HEALTH HISTORY

Patient Name ______________________ Date____________ Chart # ______________

Review of Symptoms

Please circle yes or no to indicate if you have had any of the following symptoms or diseases.

Neurological/Musculoskeletal		
Stroke	Yes	No
Migraine	Yes	No
Fainting	Yes	No
Weakness	Yes	No
Numbness	Yes	No
Head injury	Yes	No
Headaches	Yes	No
Arthritis	Yes	No
Muscle or joint aches	Yes	No
Fatigue	Yes	No
Memory loss	Yes	No
Seizures	Yes	No

Cardiovascular		
Swollen ankles or lower legs	Yes	No
Skipped or abnormal heart beat	Yes	No
Chest pain	Yes	No
High blood pressure	Yes	No
Heart disease	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No

Respiratory		
Pneumonia	Yes	No
Asthma	Yes	No
Chronic cough	Yes	No
Shortness of Breath	Yes	No

Head and Neck		
Vision problems or double vision	Yes	No
Dry eyes or itchy eyes	Yes	No
Glaucoma	Yes	No
Sneezing or runny nose	Yes	No
Change in smell	Yes	No
Sinus problems	Yes	No
Hoarseness	Yes	No
Neck mass	Yes	No
Enlarged lymph nodes	Yes	No
Dental, Mouth or Throat pain	Yes	No
Snoring or Sleep Apnea	Yes	No
Difficulty or painful swallowing	Yes	No
Ear infections or drainage	Yes	No
Ear fullness or earache	Yes	No
Noise in ears or head	Yes	No
Hearing loss	Yes	No
Exposure to loud sound	Yes	No
Dizziness	Yes	No
Facial Paralysis or numbness	Yes	No

Infections		
AIDS	Yes	No
HIV	Yes	No
Tuberculosis	Yes	No
Syphilis	Yes	No
Chicken pox	Yes	No
Mumps	Yes	No
Lymes disease	Yes	No

Emotional		
Depression	Yes	No
Excessive stress	Yes	No
Anxiety	Yes	No
Suicidal tendencies	Yes	No

Genital/Urinary		
Urinary burning	Yes	No
Kidney disease	Yes	No
Prostate problems	Yes	No
Pregnancy	Yes	No

Dermatologic		
Rashes	Yes	No
Psoriasis	Yes	No
Skin Cancers	Yes	No

Endocrine		
Thyroid problems	Yes	No
Diabetes	Yes	No

Gastrointestinal		
Constipation	Yes	No
Diarrhea	Yes	No
Ulcer	Yes	No
Heartburn	Yes	No
Liver disease or Hepatitis	Yes	No
Nausea	Yes	No

General		
Weight loss	Yes	No
Cancer	Yes	No
Fever or chills	Yes	No
Trouble sleeping	Yes	No
Excessive bleeding	Yes	No
Easy bruising	Yes	No

Other ______________

MD Initials________________