WAGNER
EAR NOSE & THROAT

PATIENT REGISTRATION

Patient Name: _____Preferred Name:_____
Patient Date of Birth _____/_____/_____

If Minor: Mother's Name _____ Phone: _____
Father's Name _____ Phone: _____
OR Legal Guardian _____ Phone: _____

Patient Age: _____ months / years old Sex: M F Social Security Number _____-_____-_____

Please Circle One: Single Married Widowed Divorced

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email Address: _____

Family Doctor & Location: _____
(First & Last Name) (city & state)

Pharmacy Name & Location: _____

EMERGENCY CONTACTS –
Persons we may speak with about your/patient's health information (in addition to those listed above)

NAME	RELATIONSHIP	PHONE #/S

Information we are required to ask
We are required by the Federal Government to ask and collect the following information on race, ethnicity, sexual identification, gender orientation, employment status and language preferences. We appreciate you providing us with this information.

RACE
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian or Other Pacific Islander
White
Other (please specify) _____

Unreported/Decline to Report

ETHNICITY
Hispanic or Latino
Not Hispanic or Latino

LANGUAGE PREFERENCE: _____

SEXUAL IDENTIFICATION _____
Straight or heterosexual Lesbian, gay, or homosexual Bisexual
Something else Don't know Decline

GENDER ORIENTATION
Female Male Transgender male/Trans man/Female-to-male
Transgender female/Trans woman/Male-to-female
Genderqueer, neither exclusively male nor female Decline

EMPLOYMENT STATUS (circle one)
Employed / Not Employed / Retired
Occupation: _____

Is this visit due to an Automobile or Worker's Compensation Injury? Yes No
If yes, please provide the following information:
Name of Auto or Workers Comp Carrier_____Claim #_____

Claim Adjustors Name_____ Phone #_____ Fax #_____

Claims Address_____

SYMPTOMS/REASON FOR VISIT:

Medical/Surgical History: (example: high blood pressure, diabetes etc.)

Family History: _____

SMOKING:

Current every day smoker
Current some day smoker
Former smoker
Never smoker
Heavy tobacco smoker
Light tobacco smoker

Date Patient Quit: Jan Feb Mar April May June July Aug Sept Oct Nov Dec Year
_____

ALCOHOL: Yes No Type: Beer Liquor Wine
# of drinks Frequency
_____ / week month year Socially Minimally Infrequently Frequently

If you have a list of **current** medications with you, we can take a copy. Otherwise, please list below:

Allergies to medications: Yes No If yes, which Medications:_____

PATIENT SIGNATURE (or responsible party) by signing you attest that you have been provided a copy of Wagner Ear Nose & Throat's Welcome Letter._____