WAGNER
EAR NOSE & THROAT

PATIENT REGISTRATION

TODAY'S DATE: ____/____/____

Patient 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: _____

Insurance Information: Is patient the insurance policy holder? Yes ☐ No ☐ If no, please provide the following:
Insurance holder's name: _____ Date of Birth: ____/____/_____
Social Security Number: _____-____-_____ Relationship to Patient: _____
Ph: _____ Address: _____ City: _____ State: ___ Zip: _____

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

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

LANGUAGE PREFERENCE: _____

EMPLOYMENT STATUS (circle one)

Employed / Not Employed / Retired

Occupation: _____

PATIENT HEALTH INFORMATION

What symptoms are bothering you most today?

_____

Are you being treated for any medical diagnosis?(Example: high blood pressure, Diabetes, Thyroid Disorder)

_____

List of Surgeries: _____

Applicable Family History: (Ear, Nose, Throat related):

_____

_____

Current Height: _____feet _____ inches **Most Recent Weight:** _____ lbs.

_____

SMOKING STATUS:

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

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

_____

ALCOHOL INTAKE: ☐ Yes ☐ No Type: ☐ Beer ☐ Liquor ☐ Wine

# of drinks Frequency

_____ / week month year ☐ Socially ☐ Minimally ☐ Infrequently ☐ Frequently

_____

Please list all medications you are taking (including over-the-counter and vitamins):

_____

_____

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

_____

_____

PATIENT SIGNATURE (or responsible party)

_____DATE:_____