To Our Patients:

As of July 2017, Westwood ENT has transitioned to Electronic Medical Records.

It is required that all patients update their demographic and medical history information *before* arriving to their appointment. Failure to do will affect your appointment time and may result in rescheduling the appointment entirely.

Please fill out this attached paperwork and arrive to your appointment 10 minutes early *with your paperwork*. We thank you for your cooperation and ask for your patience during this process.

Westwood Ear, Nose and Throat

Visit EarNoseandThroatCT.com and CTSinusCenter.com

60 Westwood Avenue, Waterbury, CT 06708 | Tel: 203-574-5997 | Fax: 203-574-5987
17 Commons Drive, Litchfield, CT 06759 | Tel: 860-567-2000 | Fax: 203-574-5987
29 Hospital Hill Road, Sharon, CT 06069 | Tel: 860-364-1264 | Fax: 860-567-2009
4 Corporate Drive, Shelton, CT 06484 | (203) 712-7579 | Fax (203) 513-2785

Westwood Ear, Nose & Throat, P.C.
Registration Form

Patient Information				
Patient's Last Name	First Name , Middle Initial	Circle One	Circle One	Marital Status
		Mr. Mrs. Ms.	Sex: M F	Single, Mar, Sep

Mailing Address		City	State	Zipcode	Spouse/Partner name
Birthdate	CellPhone #	Home Phone #			Work #

IF PATIENT IS A MINOR, parent or guardian name and employer information:

Email Address	Patient's Employer and Occupation

Who Referred You?	Phone #:

Primary Care Doctor?	Provider Phone #:

How did you hear about us? Doctor Billboard Relative/Friend Internet TV Other:_____

Allergies to Medications?	Pharmacy Name	Location

INSURANCE INFORMATION PLEASE GIVE YOUR LICENSE/ID AND INSURANCE CARDS TO THE RECEPTIONIST

Name of person who holds insurance	Birthdate	Address (if different)	
Social Security	Employer	Employer Address	Employer Phone #

IN CASE OF EMERGENCY

Name of relative or friend	Relationship	Phone#

Race	Ethnicity	Primary Language	Preferred Contact Method
White	Hispanic or Latino	English	Email
Other	Not Hispanic or Latino	Spanish	Home
Native Hawaiian	Decline to State	Other	Mail
Other Pacific Islander		Decline to State	Mobile
Black or African American			Work
Asian			
American Indian			
Alaskan native			
Decline to State			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Westwood Ear, Nose and Throat, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian Signature **Date**

Patient Name: **Account No.** **DOB:**

Patient Medical History (p. 1): Please provide the following medical information to the best of your ability:

Date: **Age:**	**List any ALLERGIES TO MEDICATIONS:**
What are your concerns for today's visit?:	

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No	
Diabetes	☐	☐	
Hypertension (high blood press)	☐	☐	
Thyroid Problems	☐	☐	
Heart Disease/cholestrol probs	☐	☐	
Heart palpitation	☐	☐	
Respiratory problems	☐	☐	
Stomach or intestinal problems	☐	☐	
Allergy problems/therapy	☐	☐	
Kidney problems	☐	☐	
Neurological problems	☐	☐	
HIV / Hepatitis	☐	☐	
Other Medical Diagnosis	☐	☐	

2) Please list any operations (and dates) you have every had *(including tonsils & adenoids)*:

3) Please list any current medications (and amounts, times per day):
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History:	Yes	No	**Please list details below:**
Do you smoke: List how much	☐	☐	
If no, did you smoke previously?	☐	☐	
How many times/week do you drink alcohol?			
What type of alcohol do you prefer?			
What is your occupation?			

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing problems	☐	☐	
Allergy	☐	☐	
Nasal Polyps	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	
Heart problems	☐	☐	

Reviewed by:

Date: ____/____/____

Patient Name: **Account No.** **DOB:**

Patient Medical History (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today.

		Yes	No	Current		Yes	No	Current
ALLERGY	sneezing	☐	☐	☐	post-nasal drip	☐	☐	☐
	environmental allergy	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	vertigo	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	sense of smell problem	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
EYES	eye pain	☐	☐	☐	watery or itchy eyes	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
NEURO	headache	☐	☐	☐	passing out	☐	☐	☐
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

PLEASE STOP HERE

Reviewed by: