Registration

Race_____ Ethnicity _____Male _____Female_____ Date_____

Marital Status _____E-mail Address_____

Patients Legal Name_____

Legal Guardian Names_____

_____

Patients SSN_____ Patients Date of Birth_____

Address_____City_____State_____Zip_____

Home Phone _____Work Phone _____Cell_____

Preferred Contact Method: Phone Email Letter Fax (Circle one)

Can we leave a detailed message: YES or NO

Primary Care Physician_____ Referring Physician_____

Spouse_____ Phone_____

Occupation_____ Employer_____

PLEASE LIST AN EMERGENCY CONTACT

Name_____Relationship_____

Phone_____

Complete this section only if someone other than the patient is financially responsible

Responsible Party_____

Address_____City_____State_____Zip_____

Phone_____ Relationship to Patient_____

Insurance Information

Patients Name: _____ Today's Date_____

Primary Insurance

Name of Insurance: _____

Insured's Name_____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

Policy ID number: _____ Group number: _____

Secondary Insurance

Name of Insurance: _____

Insured's Name_____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

Policy ID number: _____ Group number: _____

Our office will file for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, copay, and non-covered service amounts.

I authorize the release of any medical information necessary to process my claim.

I authorize payment of medical and surgical benefits to Dr. Renee Walker, D.O.

By signing below you state that you have read the above statements and agree to all conditions.

Patients or Responsible Party: _____

Date: _____

Otolaryngology of Joplin
DBA Joplin Ear, Nose & Throat
Authorization for Release of Information
Dr. Renee Walker & Dr. Suzanne Long
1920 E. 32nd St.
Joplin, MO 64804
(417) 781-4613

Notice of Privacy Practices Acknowledgement Form

In the course of providing service to you, we create, receive and store health information about you. It is often necessary to use and share your health information with others to ensure you receive the appropriate medical treatment, receive payment and perform administrative tasks in our office such as filing insurance claims on your behalf.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. As described in our **Notice of Privacy Practices**, the use and disclosures of your health information for treatment purposes not only includes care and services provided here, but also as may be necessary for you to receive follow-up care from another health professional.

We use and disclose your health information for the purpose of receiving payment for our services, which includes: 1) submission to a billing agent or vendor, 2) to third-party payers or insurers for claims review, determination of benefits and payment, 3) to auditors hired by third-party payers and insurers and 4) other aspects of payments described in the **Notice of Privacy Practices.**

When you sign this document, you agree that we may use and disclose your health information for the purpose of treatment, payment and to perform the necessary administrative functions in our office.

You have the right to restrict the use and disclosure of your health information for the purpose of treatment, payment and administrative duties. However, as described in our **Notice of Privacy Practices**, we are not obligated to the restrictions. If we do agree to the restriction, it is binding on us.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purpose of treatment, payment and administrative functions. I acknowledge that a copy of **Notice of Privacy Practices** from Renee A. Walker, D.O. was made available to me to review.

_____ _____

Patient/Other Signature Date

_____

Print name

If signing as a personal Representative of the patient, describe the **relationship to the patient** and the source of authority to sign this form.

_____

Pharmacy

Name, Location & Telephone #:_____

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

_____

Medical History

Please check off any of the following medical conditions that you currently have:

- ☐ NONE
- ☐ Cancer: Bone
- ☐ Cancer: Brain
- ☐ Cancer: Breast
- ☐ Cancer: Cervical
- ☐ Cancer: Chronic lymphocytic leukemia
- ☐ Cancer: Colon
- ☐ Cancer: Skin - Squamous cell carcinoma
- ☐ Cancer: Other
- ☐ Cardio: Arrhythmia
- ☐ Cardio: Atrial fibrillation
- ☐ Cardio: Cardiomyopathy
- ☐ Cardio: Congestive heart failure
- ☐ Cardio: Coronary artery disease
- ☐ Cardio: Hyperlipidemia/High Cholesterol
- ☐ Cardio: Hypertension/High blood pressure
- ☐ Cardio: Myocardial infarction/Heart attack
- ☐ Cardio: Valve disease; valve prolapse, stenosis, or "leaky" valve
- ☐ Cardio: Other
- ☐ Endocrine: Diabetes
- ☐ Endocrine: Diabetes, Type 1
- ☐ Endocrine: Diabetes, Type 2
- ☐ Endocrine: Pituitary adenoma or other pituitary problem
- ☐ Endocrine: Thyroid disease
- ☐ Endocrine: Other
- ☐ General: Eating disorder
- ☐ General: Obesity
- ☐ Cancer: Endometrial
- ☐ Cancer: Esophageal
- ☐ Cancer: Head and Neck
- ☐ Cancer: Leukemia
- ☐ Cancer: Liver
- ☐ Cancer: Lung
- ☐ Cancer: Lymphoma
- ☐ Cancer: Myeloma
- ☐ GI: Liver Disease - Cirrhosis
- ☐ GI: Liver Disease: Sclerosing Cholangitis
- ☐ GI: Reflux/GERD
- ☐ GI: Other
- ☐ Uro: Benign prostatic hypertrophy (large prostate)
- ☐ Uro: End stage renal disease (kidney failure)
- ☐ Uro: Incontinence
- ☐ Uro: Kidney Stones
- ☐ Uro: Recurrent urinary tract infections
- ☐ Uro: Urinary/kidney reflux
- ☐ Uro: Other
- ☐ Ob/Gyn: Endometriosis
- ☐ Ob/Gyn: Fibroids
- ☐ Ob/Gyn: HPV (Papilloma virus/warts)
- ☐ Ob/Gyn: Polycystic ovary disease
- ☐ Ob/Gyn: Pregnancy history
- ☐ Ob/Gyn: Other
- ☐ Immuno: HIV
- ☐ Immuno: Immunodeficiency
- ☐ Immuno: Other
- ☐ Lymph: Anemia
- ☐ Cancer: Ovarian
- ☐ Cancer: Prostate
- ☐ Cancer: Pancreas
- ☐ Cancer: Sarcoma (soft tissue)
- ☐ Cancer: Skin - Basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - Merkel cell carcinoma
- ☐ Neuro: Cerebral palsy
- ☐ Neuro: CVA/Stroke
- ☐ Neuro: Dementia
- ☐ Neuro: Developmental delay
- ☐ Neuro: Headaches Cluster
- ☐ Neuro: Headaches Migraine
- ☐ Neuro: Headaches Muscular Tension
- ☐ Neuro: Headaches (specify type)
- ☐ Neuro: MS (Multiple sclerosis)
- ☐ Neuro: Parkinson's
- ☐ Neuro: Seizures
- ☐ Neuro: Other
- ☐ Ophth/Opt: Blindness
- ☐ Ophth/Opt: Macular degeneration
- ☐ Ophth/Opt: Cataracts
- ☐ Ophth/Opt: Glaucoma
- ☐ Ophth/Opt: Detached retina
- ☐ Ophth/Opt: Other
- ☐ Psych: Anxiety
- ☐ Psych: Bipolar disorder
- ☐ Psych: Depression
- ☐ Psych: Personality Disorder
- ☐ Psych: Psychosis
- ☐ Psych: Schizophrenia
- ☐ Psych: Other
- ☐ Pulm: Asthma

- ☐ General: Sexually transmitted infection
- ☐ GI: Barrett's Esophagus
- ☐ GI: Cholecystitis (gallbladder disease) or gallstones
- ☐ GI: Cirrhosis
- ☐ GI: Diverticulitis
- ☐ GI: Diverticulosis
- ☐ GI: Hemorrhoids
- ☐ GI: Incontinence
- ☐ GI: Inflammatory bowel disease
- ☐ GI: Irritable bowel syndrome
- ☐ GI: Liver Disease: Auto-Immune Hepatitis
- ☐ GI: Liver Disease - Hepatitis
- ☐ GI: Liver Disease - Hepatitis A
- ☐ GI: Liver Disease - Hepatitis B
- ☐ GI: Liver Disease - Hepatitis C

- ☐ Vasc: Peripheral artery disease
- ☐ Vasc: Carotid stenosis

- ☐ Lymph: Bleeding disorder/Hemophilia
- ☐ Lymph: Blood clotting disorder
- ☐ Lymph: Neutropenia (low white blood count)
- ☐ Lymph: Sickle cell anemia
- ☐ Lymph: Thrombocytopenia (low platelets)
- ☐ Lymph: Other
- ☐ Ortho: Arthritis
- ☐ Ortho: Degenerative joint disease
- ☐ Ortho: Osteoporosis
- ☐ Ortho: Spinal stenosis
- ☐ Ortho: Other
- ☐ Neuro: ALS
- ☐ Neuro: Alzheimer's
- ☐ Neuro: Autism
- ☐ Neuro: Cerebral (brain) aneurysm

- ☐ Vasc: Abdominal aortic aneurysm
- ☐ Vasc: Thoracic aortic aneurysm

- ☐ Pulm: Bronchiectasis
- ☐ Pulm: COPD
- ☐ Pulm: Cystic Fibrosis
- ☐ Pulm: Emphysema
- ☐ Pulm: Obstructive sleep apnea (OSA)
- ☐ Pulm: Pulmonary Embolism
- ☐ Pulm: Pulmonary Fibrosis
- ☐ Pulm: Pulmonary Hypertension
- ☐ Pulm: Other
- ☐ Rheum: Autoimmune disorder (specify type)
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Gout
- ☐ Rheum: Lupus
- ☐ Rheum: Rheumatoid Arthritis
- ☐ Rheum: Scleroderma
- ☐ Rheum: Sjorgren's syndrome
- ☐ Rheum: Other

- ☐ Vasc: Other
- ☐ Other

Surgical History

Please tell us about your surgical history. Check all that apply.

- ☐ NONE
- ☐ Abdominal/GI: Abdominoperineal resections (APR)
- ☐ Abdominal/GI: Appendectomy
- ☐ Abdominal/GI: Bariatric surgery (specify type)
- ☐ Abdominal/GI: Bowel resection
- ☐ Abdominal/GI: Cholecystectomy (gallbladder)
- ☐ Abdominal/GI: Colectomy - Colon resection
- ☐ Abdominal/GI: Colectomy - Diverticulitis
- ☐ Abdominal/GI: Colectomy - Inflammatory bowel disease
- ☐ Abdominal/GI: Colostomy
- ☐ Abdominal/GI: Esophagectomy
- ☐ Abdominal/GI: Exploratory bowel surgery
- ☐ Abdominal/GI: Gastrectomy (stomach resection)
- ☐ Abdominal/GI: Hepatectomy (liver resection)
- ☐ Abdominal/GI: Hemorrhoidectomy
- ☐ Abdominal/GI: Hernia repair
- ☐ Abdominal/GI: Liver Shunt
- ☐ Abdominal/GI: Liver transplant
- ☐ Abdominal/GI: Low anterior resection
- ☐ Abdominal/GI: Pancreas resection
- ☐ Abdominal/GI: Splenectomy
- ☐ Abdominal/GI: Other
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Other
- ☐ Cosmetic: Breast augmentation
- ☐ Cosmetic: Breast reduction
- ☐ Cosmetic: Eyelid (blepharoplasty)
- ☐ Cosmetic: Facelift
- ☐ Cosmetic: Liposuction
- ☐ Cosmetic: Rhinoplasty
- ☐ Cosmetic: Tummy tuck
- ☐ Cosmetic: Other
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary artery bypass surgery (CABG)
- ☐ Heart: Heart transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Pacemaker
- ☐ Heart: PTCA (Percutaneous transluminal coronary angioplasty)
- ☐ Heart: Thoracic aortic aneurysm repair
- ☐ Heart: Other
- ☐ Lymph: Lymph node biopsy (specify location)
- ☐ Lymph: Other
- ☐ Neurosurgery: Craniotomy
- ☐ Neurosurgery: Pituitary
- ☐ Neurosurgery: Spine - Discectomy
- ☐ Neurosurgery: Spine - Fusion
- ☐ Neurosurgery: Spine - Hardware
- ☐ Neurosurgery: Spine - Laminectomy
- ☐ Neurosurgery: Tumor removal
- ☐ Neurosurgery: VP shunt
- ☐ Neurosurgery: Other
- ☐ Ob/Gyn: Bilateral tube ligation (tube tie)
- ☐ Ob/Gyn: Caesarean section
- ☐ Ob/Gyn: Dilation and curettage (D&C of uterus)
- ☐ Ob/Gyn: Hysterectomy - Caesarean section
- ☐ Ob/Gyn: Hysterectomy - Cervical cancer
- ☐ OB/Gyn: Hysterectomy - Uterine cancer
- ☐ Ob/Gyn: Oophorectomy (ovary resection)
- ☐ Ob/Gyn: Tubal Ligation
- ☐ Ob/Gyn: Other
- ☐ Ophth/Opt: Cataract surgery
- ☐ Ophth/Opt: Corneal surgery
- ☐ Ophth/Opt: Glaucoma surgery
- ☐ Ophth/Opt: Injections
- ☐ Ophth/Opt: Lasik
- ☐ Ophth/Opt: Lid
- ☐ Ophth/Opt: Macular hole
- ☐ Ophth/Opt: Retinal detachment repair
- ☐ Ophth/Opt: Laser retinal surgery
- ☐ Ophth/Opt: Other
- ☐ Ortho: Carpal tunnel
- ☐ Ortho: Hip arthroscopic surgery
- ☐ Ortho: Hip replacement
- ☐ Ortho: Knee arthroscopic surgery
- ☐ Ortho: Knee replacement

- ☐ Ortho: Shoulder arthroscopic surgery
- ☐ Ortho: Shoulder replacement
- ☐ Ortho: Surgical fracture repair (ORIF - specify bone)
- ☐ Ortho: Tumor resection
- ☐ Ortho: Other
- ☐ Pulm: Lung transplant
- ☐ Pulm: Pleurodesis
- ☐ Pulm: Pneumonectomy (lung resection)
- ☐ Pulm: Other
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: MOHs resection
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Wide local resection
- ☐ Skin: Other
- ☐ Uro: Cystectomy
- ☐ Uro: Implant
- ☐ Uro: Kidney stone removal
- ☐ Uro: Kidney transplant
- ☐ Uro: Nephrectomy (kidney resection)
- ☐ Uro: Orchiectomy (testicle resection)
- ☐ Uro: Prostatectomy - Prostate Cancer
- ☐ Uro: Prostatectomy - TURP
- ☐ Uro: Other
- ☐ Vascular: Abdominal aortic aneurysm repair
- ☐ Vascular: AV shunt (for dialysis access)
- ☐ Vascular: Carotid endarterectomy
- ☐ Vascular: Vascular bypass (leg vessels)
- ☐ Vascular: Other
- ☐ Breast: Lumpectomy (Both Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Ortho: Carpal tunnel
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitis
- ☐ Colon (Colectomy) : Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Esophagectomy
- ☐ Eye: Cataract
- ☐ Eye: Glaucoma Surgery
- ☐ Eye: Laser Surgery
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastrectomy
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Neprectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Lymph Node Excision
- ☐ Neuro: Crani
- ☐ ORIF
- ☐ Ovaries (Oophorectomy) : Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spine: Discectomy
- ☐ Spine: Fusion
- ☐ Spine: Hardware
- ☐ Spine: Laminectomy
- ☐ Uterus (Hysterectomy): Cesearean Section
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other

ENT History

Please check off any of the following procedure you have had and provide date of procedure:

ENT Disease History

- ☐ None
- ☐ Cancer: Head and neck Cancer - specify location
- ☐ Cancer: Lymphoma, neck nodes
- ☐ Cancer: Sinus or nasal cavity
- ☐ Cancer: Skin - basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - other type - specify
- ☐ Cancer: Skin - squamous cell carcinoma
- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Hearing loss
- ☐ Ear: Mastoiditis
- ☐ Ear: Other
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Otosclerosis
- ☐ Ear: Tinnitus (ringing or other noise of the ear)
- ☐ Ear: Vertigo
- ☐ General: Facial fractures
- ☐ General: Other
- ☐ General: reflux
- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Subglottic stenosis
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord nodules
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord polyps
- ☐
- ☐ Larynx: Other
- ☐ Nasal: Deviated septum
- ☐ Nasal: Epistaxis (nose bleeds)
- ☐ Nasal: Loss of smell
- ☐ Nasal: Nasal fracture
- ☐ Nasal: Nasal obstruction
- ☐ Nasal: Other
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Nasal: Turbinate hypertrophy
- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Hyperparathyroidism
- ☐ Neck: Neck mass
- ☐ Neck: Other
- ☐ Neck: Parotid tumor
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Sialolithiasis (stone of the salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules
- ☐ Oral: other
- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsillitis
- ☐ Oral: Ulcers
- ☐ Other

_____

ENT Surgical History

- ☐ None
- ☐ Ear: Acoustic neuroma resection
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear)
- ☐ Ear: Other - specify
- ☐ Ear: Otoplasty
- ☐ Ear: Stapedectomy
- ☐ Ear: Tympanoplasty (repair ear drum)
- ☐ Head and neck: Lymph node biopsy
- ☐ Head and neck: Neck dissection
- ☐ Head and neck: Other - specify
- ☐ Head and neck: Parathyroidectomy
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Resection in mouth or throat - specify
- ☐ Head and neck: Skin graft
- ☐ Head and neck: Skin resection
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroidectomy
- ☐ Head and neck: Tracheotomy
- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other - specify
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction
- ☐ Throat: Adenoidectomy
- ☐ Throat: Other - specify
- ☐ Throat: Sleep apnea surgery - uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other

_____

Medications

Please list all medications you are currently taking:

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Allergies

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Social History

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

When did you start smoking? _____ Number of packs per day: _____

When did you quit smoking? _____ Total number of years smoking: _____

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day
- ☐ Other: _____

Family History

Please list any family history of illness or disease:

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Let us know if there is anything else you would like to disclose:

_____

_____

Surgery

If Dr. Walker Recommends surgery you will be escorted to the Surgery Coordinator. She/he will answer specific questions about the surgery scheduling process, discuss the paperwork and test involved, and complete all pre-certification/authorization if your insurance requires it.

We would like to make you aware that, the amount of money collected for prepayment on surgeries through the office is an approximate estimate of benefits from the information that is collected from your insurance company. This means you may receive a bill or refund after we have received remit from your insurance company.

After you have read and understand the above statements please sign and date below

Patient, Parent or Guardian: _____

Date:_____

I allow the people listed below to have access to my medical information

If you have no one allowed to do so, please draw a line through list.

1._____

2._____

3._____

4._____

5._____

Please Sign and Date

Patient/Legal Guardian: _____

Date: _____