# WESTERN MICHIGAN ENT, PC

EAR • NOSE • THROAT

Board Certified • Ear, Nose, Throat and Orofacial Surgery

J. Ben Hengy, DO
Andrew E. Mendians, DO
Stacey Bonecutter, FNP
Brenda McCann, Au.D, CCA-A
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## Patient Registration Form

Date: ________________ Patient Name: ________________________________________________
Last First Middle

Address: ______________________________ City & State: ______________ Zip code: ________

Email Address: ______________________ Home Phone: ______________ Cell Phone: __________

Date of Birth _____/_____/_____ If a Minor: Father & Mother's names ________________________

Name of Step Parent (s) ______________________ Foster Parent: ___________________________

Guardian's Name ________________________ Guardianship Paperwork: ☐ Yes ☐ No

Sex: Male Female Maritial Status: S M W D Student: ☐ Yes ☐ No

Employer: ______________________ Occupation/Title: ______________ ☐ Full time ☐ Part time

Work Phone: ______________________ ☐ Retired Unemployed: ☐ Yes ☐ No

**EMERGENCY INFORMATION: (Someone that does not live with you)**

Name: ______________________ Relationship: ______________ Phone number: ____________

**POLICY SUBSCRIBER'S INSURANCE AND EMPLOYMENT INFORMATION**

Policy Holder's Name: ______________________ Date of Birth: _____/_____/_____ ☐ Retired

Policy Number: ________________ Group Number: ______________ Work Phone: ____________

Employer: ____________________________ Address: ________________________________

Human Resource Contact Name: ______________________ Phone number ____________________

I consent to the use/disclosure of my protected health information by Western Michigan ENT, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Western Michigan ENT, P.C. This is stated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Notice of Privacy Rules have been given to me and I have signed an acknowledgement stating this, which is in my file.

Patient/Parent/Guardian Signature: ____________________________________ Date: ______________

**FOR INSURANCE CARRIERS THAT WESTERN MICHIGAN ENT, PC DOES NOT PARTICIPATE WITH, PLEASE READ AND SIGN BELOW:**

I understand that Western Michigan ENT P.C. does not participate with or accept assignment with my insurance carrier. I will be fully responsible for any balance that is not paid by my insurance carrier.

Patient/Parent/Guardian Signature: ____________________________________ Date: ______________

**CONSENT FOR TREATMENT OF A MINOR or PATIENT UNDER GUARDIANSHIP**

Parent/Guardian Consent: By signing this, I am stating I am the legal guardian of the patient and am giving consent/permission to J. Ben Hengy, D.O. and/or Andrew E. Mendians, D.O and/or Stacey Bonecutter, FNP to treat my child/ward.

Patient/Parent/Guardian Signature: ____________________________________ Date: ______________

**Over →**

## MEDICAL INFORMATION

Who is your primary care physician: ______________________ Pharmacy: ______________________

Prescription and over the counter Medications you are taking and dosages (example: Claritin 10 mg): ______________________

______________________

______________________

Medications you are allergic to and reaction: ______________________

______________________

## MEDICAL HISTORY/REVIEW OF SYSTEMS

Please review all of the following symptoms line by line. If you are currently having any of the following symptoms within the {brackets} please circle the specific symptom. If you have not had any of the symptoms within the {brackets} please put a check on the line so we know you have reviewed the category.

| | | | | | | |
|---|---|---|---|---|---|---|
| ___ CONSTITUTIONAL | { Appetite | Weight Change | Fever/Chills | Fatigue } | | |
| ___ SKIN | { Itching | Rash | Hives | Skin Cancer } | | |
| ___ ALL/IMM | { Cancer | Allergies | Food Allergies } | | | |
| ___ ENT | { Hearing Loss | Tinnitus | Ear Infection | Ear Pain | Sore Throat | Sinus |
| | { Sneezing | Congestion | Nose Bleeds | Hoarseness | Swallowing Problems } | |
| ___ EYES | { Vision Loss | Itchy eyes | Blurred Vision | Cataracts} | | |
| ___ RESP | { Cough | Wheezing | Shortness of Breath } | | | |
| ___ CARDIO | { Chest Pain | Swelling | Fainting | High Blood Pressure } | | |
| ___ GI | { Indigestion | Heartburn | Nausea | Diarrhea } | | |
| ___ GU | { Bloody Urine | Painful Urination | Decreased Flow | Decreased Force | Night Urination } | |
| ___ ENDO | { Diabetes | Steroid use | Breast Mass | Thyroid } | | |
| ___ MUSCULOSK | { Joint Pain | Bursitis | Gout | Stiffness | Back Pain } | |
| ___ NEURO | { Seizures | Dizziness | Stroke | Speech | Tingling | .Headaches } |
| ___ PSYCH | { Anxious | Depression | Stress } | | | |
| ___ HEME/LYMPH | { Anemia | Bruise Easily | Bleeding | Swollen Glands } | | (________ DR. ROS) |

___ All other chronic problems or symptoms ______________________

______________________

Are you a smoker? ☐ Yes ☐ No ☐ Quit How long have you been a smoker? ________ Packs per day? ________

If you quit, how long were you a smoker? ________ Packs per day? ________ How long ago did you quit? ________

Do you use alcohol? ☐ Never ☐ Rarely ☐ Moderate ☐ Severe

Do you use street drugs? ☐ Yes ☐ No ☐ Quit If you do, what type and how often? ______________________

Please list all surgeries you have had and the year you had it: ______________________

______________________

Family History: Check all of the following that pertain to your family and who was affected by the following. (Father/Mother Paternal or Maternal Grandparent/Uncle/Aunt/Brother/Sister/Children.)

☐ Hearing Loss __________ ☐ Cancer __________ ☐ High Blood Pressure __________

☐ Allergies/Sinus __________ ☐ Diabetes __________ ☐ Other __________

☐ Ear Problems __________ ☐ Heart Disease __________ ☐ Other __________

**REFERRAL INFORMATION** - Please fill in the name of the person that referred you or where you heard about us.

☐ Doctor __________ ☐ Hospital __________ ☐ Newspaper __________

☐ Lecture __________ ☐ Friend/Family __________ ☐ Newsletter __________

☐ Event __________ ☐ TV Commercial __________ ☐ Radio Ad __________

☐ Website __________ ☐ Word of Mouth __________ ☐ Other __________