David O. Volpi, M.D. FACS

NEW PATIENT REGISTRATION FORM

Date_____

PATIENT INFORMATION

Whom may we thank for referring you?_____
Name (Last, First, MI)_____ Age_____
Gender_____ Date of Birth _____/ _____/ _____ Marital Status_____
Address_____ Apt#_____
City_____ State_____ Zip_____
SSN:_____/_____/_____ Email _____
Home Phone_____ Work Phone_____ Ext_____
Mobile Phone_____ Other Phone_____
Employer_____
Emergency Contact_____ Phone_____

INSURANCE INFORMATION:

Please note that if your carrier requires Pre-Authorization or Pre-Approval you are required to obtain it prior to your appointment. You may need to check with your carrier if you have a waiting period.

Primary Ins_____ Ins Phone_____
Primary Ins Address_____
Subscriber_____ Date of Birth_____/ _____/ _____ Relation to Patient: ☐Self ☐Spouse ☐Child ☐Other
Ins ID#_____ Ins Grp#_____
Secondary Ins_____ Ins Phone_____
Secondary Ins Address_____
Subscriber_____ Date of Birth_____/ _____/ _____ Relation to Patient: ☐Self ☐Spouse ☐Child ☐Other
Secondary Ins ID#_____ Ins Grp#_____

OTHER MEDICAL CONTACTS

Primary Care/Physician_____ Phone _____
Address_____
Pharmacy_____ Phone _____
Address_____

DISCLOSURE OF BENEFITS

I have received a copy of the HIPAA Privacy Notice and authorize release of information concerning my health care, advice and treatment provided for the purpose of evaluating and / or administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the physician.

Signature of Patient or Patient Representative: _____ Date_____

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993 Park Avenue, Suite C, New York, NY 10028
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www.eosentny.com

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MEDICAL HEALTH HISTORY

Patient Name_____ Today's Date_____

Patient Date of Birth_____/ _____/ _____ Age_____ Gender ☐ Male ☐ Female

Occupation_____ Height _____ Weight_____

REASON FOR CONSULTATION

☐ Ear Infection	☐ Sleep Apnea	☐ Foreign Body in Ear/Nose	☐ Headache	☐ Tonsil Problems
☐ Ear Aches	☐ Snoring	☐ Sore Throat	☐ Vertigo/Dizziness	☐ Other: _____
☐ Ear Discharge	☐ Sinus Problems	☐ Swallowing Difficulty	☐ Allergies	_____
☐ Ringing in Ears	☐ Nasal Obstruction	☐ Mouth/Tongue Sores	☐ Cough	_____
☐ Hearing Loss	☐ Nose Bleeds	☐ Thyroid Nodule	☐ Hoarseness	_____
☐ Earwax Build-Up	☐ Nose Fracture	☐ Neck Mass	☐ Post Nasal Drip	_____

MEDICATIONS List ALL medications you are currently taking including herbs, supplements & over the counter medications.

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

☐ Hypertension	☐ Liver Disease	☐ Pregnant	☐ Diabetes
☐ Heart Disease	☐ Sleep Apnea	☐ Cancer	☐ Other_____
☐ Kidney Disease	☐ Thyroid Disease	☐ Bleeding Disorder	_____

MEDICATION ALLERGIES

Medication: Reaction:

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY

Surgery: Date:

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

☐ CIGARETTES # per day _____ # of years _____ ☐ Discontinued

☐ ALCOHOL # per week _____

Other health concerns: _____

_____

_____

Physician Signature: _____ Date_____