Dr. Malis
FAMILY ENT & AUDIOLOGY

New Patient Registration

Patient:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: _____ Sex: M / F Social Security: _____

Email: _____

Race:

___American Indian or Alaska Native
___Asian
___Black or African American
___Hispanic
___Caucasian

Ethnicity:

___Hispanic
___Not Hispanic or Latino
___Refuse to Report
___Other

Preferred Language:

__English
__Spanish
__Other_____

RESPONSIBLE PARTY INFORMATION – PERSON INSURANCE IS UNDER

(Medicaid patients that are minors please fill out ***Parent/Guardian*** information*)*

Last Name: _____Middle Initial: _____ First: _____

Date of Birth: _____ **Sex**: M / F **Social Security**: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: ( ) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: _____ Date: _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operations.

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Medical History

Have you been diagnosed with any of the following?

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Cancer
- ☐ COPD
- ☐ Congenital Heart Disease
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Downs syndrome
- ☐ Fainting spells
- ☐ Heart Burn/GERD
- ☐ Head Injuries/ Migraines
- ☐ Heart Failure/ Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease / Failure
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Respiratory disease
- ☐ Seizure / Epilepsy
- ☐ Sinus Trouble
- ☐ Skin Condition (Eczema)
- ☐ Spina Bifida
- ☐ Thyroid or Parathyroid disease
- ☐ Other: _____
  _____
  _____
  _____

Type of surgery / Reason for hospitalization **Approx. Date/Year**

_____ _____
_____ _____
_____ _____

Current Medication

_____
_____
_____
_____
_____
_____
_____

Allergies to Medications/Reactions

_____
_____
_____
_____

Social History

Who do you live with? _____
Do you have any children? Y/N
If in school, what grade are you in? _____
Do you smoke? Y/N/Former
Are you exposed second hand smoke? Y/N
Do you have any pets? Y/N

Pharmacy

Name: _____
Phone: _____

Primary Care Provide

Name: _____
Phone: _____