Don S. Respler, MD
2 South Summit Avenue Hackensack, NJ 07601
(201) 996-9200 AngelsofENT@gmail.com
www.DrRespler.com

Patient Registration Form with COVID-19 Screening (revised 3-2025)

** Bolded lines must be completed for all patients. Unbolded lines may be completed with N/C if last visit was within one year and info has not changed since last visit*

☐ *Please check this box if you need a school note for today*

Patient's Name: _____ **Date of Birth:** _____ ☐ **male** ☐ **female**

Address:_____ City, State Zip:_____

Phone 1: _____accepts text?☐yes☐no Phone 2: _____accepts text?☐yes☐no

Email: _____ Pharmacy: _____

PCP name and location: _____

Does patient have full immunizations:☐yes☐no Explanation:_____

Patient had COVID19?☐yes☐no Date_____ vaccinated?☐yes☐no # Doses:_____Last Dose Date:_____☐Pfizer ☐Moderna ☐J&J

List all individuals accompanying patient: (use back of form for additional individuals) ☐ no accompanying individuals

Name: _____ DOB: _____☐parent ☐family member ☐interpreter ☐caretaker
had COVID19?☐yes☐no Date_____ vaccinated?☐yes☐no # Doses:_____Last Dose Date:_____☐Pfizer ☐Moderna ☐J&J

Name: _____ DOB: _____☐parent ☐family member ☐interpreter ☐caretaker
had COVID19?☐yes ☐no Date_____ vaccinated? ☐yes☐no # Doses:_____Last Dose Date:_____☐Pfizer ☐Moderna ☐J&J

ENT issues (check at least one) ☐**First Visit** ☐**Follow-up** ☐**Pre-op** ☐**Post-op**

Ear Issues: ☐**pain** ☐**infection** ☐**hearing** ☐**speech delay** ☐**wax** ☐**ear mass** ☐**dizziness** ☐**ringing** ☐**something in ear** ☐ _____

Nose/Sinus: ☐**nosebleeds** ☐**infection** ☐**adenoids** ☐**congestion** ☐**sinusitis** ☐**diminished smell** ☐**fracture** ☐**deviation** ☐_____

Throat/Mouth/Sleep: ☐**tongue tie** ☐**lip tie** ☐**neck mass** ☐**restless sleep** ☐**snoring** ☐**sleep apnea** ☐**mouth breathing** ☐**strep** ☐**tonsils**
☐**GE Reflux** ☐**feeding** ☐**trach**☐**cough** ☐**sore throat** ☐**thyroid** ☐**cleft** ☐**mouth lesion** ☐**breathing difficulty** ☐_____
☐**Other Describe:**_____

Records to be reviewed? ☐**yes** ☐**no** ☐**sent via FAX** ☐**sent via email** ☐**with me** _____
☐**PCP notes** ☐**ER/UrgiCare/Hospital notes** ☐**sleep study** ☐**audiology** ☐**specialist notes** ☐**CT scan** ☐**MRI** ☐**test results other**_____

Primary Insurance Company: _____Policy number: _____
copay amt: _____ Name of Insured:_____ Insured Birthdate: _____
Secondary Insurance Company: _____Policy number: _____ ☐ no secondary
copay amt: _____ Name of Insured:_____ Insured Birthdate: _____
Referral Number: _____ exp date: _____ ☐ no referral necessary

☐**If my insurance lapsed or another insurance is primary, I am responsible for the full amount of the office visit + $50 penalty**_____(initials)
☐**I understand that no-show or unauthorized same day cancellation will incur a $25 fee** _____ (initials)
☐**I understand that surgery no-show or non-medical cancellation will incur a $100 fee** _____(initials)
By signing this form, I certify that all address, immunization,COVID, insurance and referral information is correct, complete and up-to-date.

_____ **Date:** _____
Patient signature (or parent signature for minor child with the word "mother" or "father") **MM/DD/YYYY**

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Height: _____ Weight: _____ Temp: _____degrees F

☐ **I hereby agree that the details on this form are correct and complete and that this previously completed form is valid for today's visit**

_____ **Date:** _____
Patient signature (or parent signature for minor child with the word "mother" or "father") **MM/DD/YYYY**