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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**

****

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**

NAME: _____

DATE: _____

ENT Institute of NJ

REVIEW OF SYSTEMS

☐ **reviewed by Dr. Respler**

YES NO GENERAL
- ☐ ☐ Recent weight gain
- ☐ ☐ Recent Weight Loss
- ☐ ☐ Fatigue
- ☐ ☐ ChillsFever
- ☐ ☐ Night sweats
- ☐ ☐ Change in sleep habits ☐

YES NO CARDIO/RESPIRATORY
- ☐ ☐ Chest Pain
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Heart disease
- ☐ ☐ High blood pressure
- ☐ ☐ Heart murmur
- ☐ ☐ Difficulty breathing
- ☐ ☐ Noisy Breathing
- ☐ ☐ Positive TB test
- ☐ ☐ Swollen feet

_____

YES NO SKIN
- ☐ ☐ Skin lesions
- ☐ ☐ Rashes/Eczema
- ☐ ☐ Color changes
- ☐ ☐ Hair changes
- ☐ ☐ Nail changes
- ☐ ☐ Easy bruising
- ☐ ☐ itching

YES NO EYES
- ☐ ☐ Pain
- ☐ ☐ Vision Loss
- ☐ ☐ Double vision
- ☐ ☐ Excessive tearing
- ☐ ☐ Eye infections
- ☐ ☐ Eyeglasses / Contact Lenses

YES NO UROLOGY
- ☐ ☐ Difficulty urinating
- ☐ ☐ Pain or burning
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Kidney infection or stones

YES NO NEUROLOGICAL
- ☐ ☐ Headache
- ☐ ☐ Seizures
- ☐ ☐ Dizziness
- ☐ ☐ Numbness/Tingling
- ☐ ☐ Muscle Weakness
- ☐ ☐ Depression
- ☐ ☐ Emotional Issues

YES NO MUSCULOSKELETAL
- ☐ ☐ Joint pain
- ☐ ☐ Joint Swelling
- ☐ ☐ Stiffness
- ☐ ☐ Back problems
- ☐ ☐ Neck pain
- ☐ ☐ Coordination Issues
- ☐ ☐ Paralysis

YES NO HEMATOLOGIC
- ☐ ☐ Bleeding Tendency
- ☐ ☐ Anemia
- ☐ ☐ Swollen Glands
- ☐ ☐ HIV

YES NO GASTRO-INTESTINAL
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Bloody/Black Stools
- ☐ ☐ Hiatal Hernia
- ☐ ☐ Hepatitis

YES NO ENDOCRINE
- ☐ ☐ Hot/Cold Intolerance
- ☐ ☐ Change in Voice
- ☐ ☐ Change in Energy
- ☐ ☐ Excessive Thirst
- ☐ ☐ Goiter

YES NO EAR,NOSE&THROAT
- ☐ ☐ Ear pain
- ☐ ☐ Hearing Difficulty
- ☐ ☐ Swallowing Difficulty
- ☐ ☐ Ringing in Ears
- ☐ ☐ Vertigo
- ☐ ☐ Frequent Sore Throat
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Nasal Stuffiness
- ☐ ☐ Bad Breath
- ☐ ☐ Cough
- ☐ ☐ Sinus Trouble
- ☐ ☐ Restless Sleep
- ☐ ☐ Mouth Breathing
- ☐ ☐ Snoring
- ☐ ☐ Headache
- ☐ ☐ Sleep Apnea
- ☐ ☐ Neck Mass
- ☐ ☐ GE Reflux Disease
- ☐ ☐ Tongue Tie
- ☐ ☐ Lip Tie
- ☐ ☐ Diminished Smell
- ☐ ☐ Hearing Aid(s)

YES NO ENT HISTORY Explain
- ☐ ☐ Ear infections
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Pneumonia
- ☐ ☐ Tonsilitis
- ☐ ☐ Strep
- ☐ ☐ Laryngomalacia
- ☐ ☐ Croup
- ☐ ☐ Hospitalization
- ☐ ☐ Injuries
- ☐ ☐ Surgeries

YES NO FAMILY HISTORY who?
- ☐ ☐ Sleep Apnea
- ☐ ☐ Ear infections
- ☐ ☐ Asthma
- ☐ ☐ Hearing Loss
- ☐ ☐ GE Reflux
- ☐ ☐ Tongue/Lip Tie

YES NO ALLERGIES List
- ☐ ☐ Medicine
- ☐ ☐ Food
- ☐ ☐ Environmental

YES NO MEDICINES List
- ☐ ☐ Antibiotics
- ☐ ☐ Other Meds

Normal /abnormal HISTORY Explain
- ☐ ☐ Prenatal history
- ☐ ☐ Speech
- ☐ ☐ Immunization
- ☐ ☐ COVID

YES NO ENVIRONMENT Explain
- ☐ ☐ Smoking in Home
- ☐ ☐ Pets
- ☐ ☐ Daycare
- ☐ ☐ School
- ☐ ☐ Bottle Use
- ☐ ☐ Pacifier Use
- ☐ ☐ Alcohol
- ☐ ☐ Feeding Issues
- ☐ ☐ Bed Wetting
- ☐ ☐ Thumb Sucking
- ☐ ☐ Speech Issues
- ☐ ☐ Drooling
- ☐ ☐ Nightmares
- ☐ ☐ Genetic Syndrome
- ☐ ☐ Dev Disability
- ☐ ☐ Learning Issues
- ☐ ☐ Autism
- ☐ ☐ Hyperactivity
- ☐ ☐ Behavioral Issues
- ☐ ☐ Balance Problems
- ☐ ☐ Puts things in Nose
- ☐ ☐ Puts things in ear
- ☐ ☐ Trach Dependent

Trach type/size _____

HEIGHT _____ ft _____ inches

WEIGHT _____ pounds

REASON FOR ENT VISIT and any other important issues:

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

ENT Institute of NJ

HIPAA Compliance Release Form

*This form protects the privacy of your medical records. It directs our office to release your medical information **only** to those people and entities that you choose below. We will not release any of your medical records to anyone not specified on this or any replacement HIPAA form, so **please be sure to include every doctor, school or person with whom you want us to share your medical information**.*

Patient's Name: _____ Date of Birth: _____
Address: _____

Phone _____ FAX (____)_____ _____ Email:_____

Other than my referring physician, insurance company and doctor/hospital/surgery center for coordination of ENT treatment, I authorize your office to share information with the following individual(s), department(s), doctors, relatives, schools and/or offices:
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

School Name:_____Phone# or contact:_____

I understand that I have the right to revoke or replace this authorization at any time. The revocation/replacement of this authorization must be in writing with the inclusion of my name, address, telephone number, the date of this authorization, and my signature. I am aware that my revocation/replacement will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization. This authorization will remain in effect until I revoke or replace this authorization.

I have had an opportunity to review and understand the contents of this form. By signing this form, I confirm that this HIPAA directive accurately reflects my wishes. I have signed this form voluntarily as a directive to share my medical info as described above.

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

If you have any questions or objections, please contact our HIPAA compliance lead at 201-996-9200 or via email at angelsofent@gmail.com

If signed by a personal representative other than parent, please complete the following:
****

Name of Personal Representative: _____

Relationship to patient: _____

☐ health care power of attorney ☐ legal guardian ☐ other legal authorization — A copy of documentation must be attached

Address: _____

Daytime Telephone Number:_____ E-mail:_____

By signing this form, I authorize Pediatric Otolaryngologic Associates to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act [HIPAA] of 1996) in the manner described above.

_____ Date:_____
SIGNATURE OF PERSONAL REPRESENTATIVE MM / DD / YYYY