

**Kansas University Physicians, Inc.
Patient Registration Form**

Primary Care Doctor _____
Address _____
Phone (____) _____ Fax (____) _____

KUPI Account Number _____
Medical Record Number _____

Referring Doctor _____
Address _____
Phone (____) _____ Fax (____) _____

Date _____

PATIENT'S INFORMATION

1UW87.PT1

Patient's Legal Name: First _____ M.I. _____ Last _____
Nickname (AKA) _____ Social Security # _____
Patient's Addr. _____ City _____ State _____ Zip _____
Email Address _____ Home Phone _____ Alternate Phone _____
Sex: M or F Date of Birth _____ Religion: _____ Alternate Phone Type _____
Marital Status: Single Married Divorced Widowed Separated Race: 1 - White 2 - Black 3 - Asian/Oriental 4 - Hispanic 5 - Native American 6 - Other

PATIENT'S EMPLOYER

1UW87.EMP

Patient's Employer _____ Retirement Date _____
Employer's Addr. _____ City _____ State _____ Zip _____
Work Phone _____ Work Ext _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION (Please send statements to):

1UW87.GT1

(If any information is the same as above, indicate by writing "SAME")

Patient's Relationship to Guarantor: 1 - Self 2 - Spouse 3 - Child 5 - Other 6 - Parent 10 - Other Relative 11 - Organ Donor 12 - Life Partner 15 - Ward of the Court
Guarantor's Legal Name: First _____ M.I. _____ Last _____
Guarantor's Addr. _____ City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____ Alternate Phone Type _____
Social Security # _____ Date of Birth _____ Sex: M or F Email Address _____
Guarantor's Employer _____ Retirement Date _____
Employer's Addr. _____ City _____ State _____ Zip _____
Work Phone _____ Work Ext _____

EMERGENCY CONTACT INFORMATION

1UW87.CON

Contact's Relationship to Patient: 1 - Self 2 - Spouse 3 - Child 5 - Other 6 - Parent 10 - Other Relative 11 - Organ Donor 12 - Life Partner 15 - Ward of the Court
Emergency Contact's Name: First _____ M.I. _____ Last _____
Contact's Addr. _____ City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____

PRIMARY INSURANCE INFORMATION

Insured's Relationship to Patient: 1 - Self 2 - Spouse 3 - Child 5 - Other 6 - Parent 10 - Other Relative 11 - Organ Donor 12 - Life Partner 15 - Ward of the Court
Insured's Name: First _____ M.I. _____ Last _____
Insured's Addr. _____ City _____ State _____ Zip _____
Home Phone _____ Social Security # _____ Date of Birth _____ Sex: M or F
Insured's Employer _____
Insurance Company Name _____ Phone _____
Claims Mailing Addr. _____ City _____ State _____ Zip _____
Policy/ID/Member # _____ Group/Employer ID # _____
Insurance Effective Date _____ PCP Copy _____ Specialty Copy _____ ER Copy _____

SECONDARY INSURANCE INFORMATION

Insured's Relationship to Patient: 1 - Self 2 - Spouse 3 - Child 5 - Other 6 - Parent 10 - Other Relative 11 - Organ Donor 12 - Life Partner 15 - Ward of the Court
Insured's Name: First _____ M.I. _____ Last _____
Insured's Addr. _____ City _____ State _____ Zip _____
Home Phone _____ Social Security # _____ Date of Birth _____ Sex: M or F
Insured's Employer _____
Insurance Company Name _____ Phone _____
Claims Mailing Addr. _____ City _____ State _____ Zip _____
Policy/ID/Member # _____ Group/Employer ID # _____
Insurance Effective Date _____ PCP Copy _____ Specialty Copy _____ ER Copy _____

**THE UNIVERSITY OF KANSAS
PHYSICIANS**

Otolaryngology Head & Neck Surgery

Welcome. Please complete the following health history before you see your physician.

Name _____ Birthdate _____ Date _____

Age _____ Sex Male Female

Reason for visit: (current symptoms)

1. _____

Primary Care Physician _____ And/Or Referring Provider _____

Allergies: Please list any allergies to medications or foods. Examples of reactions: Rash or hives, trouble breathing, nausea

Name	Reaction	Name	Reaction
1		4	
2		5	
3		6	

Medications: Include prescription and over-the-counter medications. Feel free to attach a printed or typed list of medications instead.

Name	Dose & Frequency	Name	Dose & Frequency
1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

Herbal Medications or Supplements:

Name	Dose & Frequency	Name	Dose & Frequency
1		3	
2		4	

Preferred Pharmacy:

Name	Address	Phone

Advance Directive/DPOA:

Do you have an Advanced Directive: Yes No Durable Power of Attorney or Guardian: Yes No Copy on file in Office? Yes No

Past Medical History:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lung/Respiratory Disease
<input type="checkbox"/> Anesthetic Complication	<input type="checkbox"/> Growth/Development Disorders	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Angina	<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Birth Defect	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Strep Throat (recurrent)
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bowel Disease	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Tobacco Abuse
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney/Bladder Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OVER

Surgical History (include dates if possible):

Procedure	Date	Procedure	Date	Procedure	Date
<input type="checkbox"/> Adenoidectomy		<input type="checkbox"/> Esophagus Surgery		<input type="checkbox"/> Septoplasty	
<input type="checkbox"/> Bronchoscopy		<input type="checkbox"/> Facial Cosmetic Surgery		<input type="checkbox"/> Sinus Surgery	
<input type="checkbox"/> Ear Surgery		<input type="checkbox"/> Heart Surgery		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Ear Tubes		<input type="checkbox"/> Laryngeal Surgery		<input type="checkbox"/> Tonsillectomy	

Family History: Please indicate the relationship of the family member who has had any of the following: (e.g. father, sister, grandparent)

	Who		Who		Who
<input type="checkbox"/> Allergy - severe		<input type="checkbox"/> Diabetes		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Dizziness		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Anesthetic complications		<input type="checkbox"/> Growth/Developmental		<input type="checkbox"/> Migraines	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Birth Defect		<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/>		<input type="checkbox"/>	

Father: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
 Mother: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
 Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
 Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____
 Sibling: Age (if living) _____ Age at Death (If Deceased) _____ Cause of death: _____

Health Maintenance:

Date of Last tetanus shot _____ Last flu shot _____ Last pneumonia shot _____

Review of Systems: Please mark if you have had any of the following symptoms in the last 3 months:

General: <input type="checkbox"/> Negative	Eyes: <input type="checkbox"/> Negative	GU: <input type="checkbox"/> Negative	Neurological: <input type="checkbox"/> Negative
<input type="checkbox"/> Activity change	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Eye itching	<input type="checkbox"/> Painful urination (Dysuria)	<input type="checkbox"/> Facial asymmetry
<input type="checkbox"/> Chills	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Incontinence (Enuresis)	<input type="checkbox"/> Headaches
<input type="checkbox"/> Sweating (Diaphoresis)	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Light-headedness
<input type="checkbox"/> Irritability	<input type="checkbox"/> Light sensitivity (Photophobia)	<input type="checkbox"/> Frequency	<input type="checkbox"/> Numbness
<input type="checkbox"/> Fever	<input type="checkbox"/> Visual disturbance	<input type="checkbox"/> Genital sore	<input type="checkbox"/> Seizures
<input type="checkbox"/> Unexpected wt. change	Respiratory: <input type="checkbox"/> Negative	<input type="checkbox"/> Blood in urine (Hematuria)	<input type="checkbox"/> Speech difficulty
HEENT: <input type="checkbox"/> Negative	<input type="checkbox"/> Sleep disturbances (Apnea)	<input type="checkbox"/> Urgency	<input type="checkbox"/> Fainting (Syncope)
<input type="checkbox"/> Facial swelling	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Urine decreased	<input type="checkbox"/> Tremors
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Choking	MS (joint/bone): <input type="checkbox"/> Negative	<input type="checkbox"/> Weakness
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Cough	<input type="checkbox"/> Joint pain (Arthralgia)	Hematologic: <input type="checkbox"/> Negative
<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Back pain	<input type="checkbox"/> Enlarged lymph node (Adenopathy)
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Inhale wheeze (Stridor)	<input type="checkbox"/> Gait problem	<input type="checkbox"/> Bruises/bleeds easily
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Joint swelling	Psychiatric: <input type="checkbox"/> Negative
<input type="checkbox"/> Ringing in ears (Tinnitus)	Cardiovascular: <input type="checkbox"/> Negative	<input type="checkbox"/> Muscle pain (Myalgia)	<input type="checkbox"/> Agitation
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Chest pain	Skin: <input type="checkbox"/> Negative	<input type="checkbox"/> Behavior problem
<input type="checkbox"/> Congestion	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Color change	<input type="checkbox"/> Confusion
<input type="checkbox"/> Runny nose (Rhinorrhea)	<input type="checkbox"/> Rapid heartbeat (Palpitations)	<input type="checkbox"/> Pale skin (Pallor)	<input type="checkbox"/> Decreased concentration
<input type="checkbox"/> Postnasal drip	GI (Gastrointestinal): <input type="checkbox"/> Negative	<input type="checkbox"/> Rash	<input type="checkbox"/> Dysphoric mood
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Abdominal distention	<input type="checkbox"/> Wound	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Dental problem	<input type="checkbox"/> Anal bleeding		<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Drooling	<input type="checkbox"/> Blood in stool		<input type="checkbox"/> Self-injury
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Constipation		<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Suicidal ideas
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Nausea		
<input type="checkbox"/> Voice change	<input type="checkbox"/> Rectal pain		
	<input type="checkbox"/> Vomiting		

THE UNIVERSITY OF KANSAS PHYSICIANS

Otolaryngology

Head & Neck Surgery

Review of Systems (ROS)

Please mark only the symptoms you CURRENTLY are experiencing

General: <input type="checkbox"/> Negative	Eyes: <input type="checkbox"/> Negative	GU: <input type="checkbox"/> Negative	Neurological: <input type="checkbox"/> Negative
<input type="checkbox"/> Activity change	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Eye itching	<input type="checkbox"/> Painful urination (Dysuria)	<input type="checkbox"/> Facial asymmetry
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HEENT: <input type="checkbox"/> Negative	<input type="checkbox"/> Sleep disturbances (Apnea)	<input type="checkbox"/> Urgency	<input type="checkbox"/> Fainting (Syncope)
<input type="checkbox"/> Facial swelling	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Urine decreased	<input type="checkbox"/> Tremors
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<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Chest pain	Skin: <input type="checkbox"/> Negative	<input type="checkbox"/> Behavior problem
<input type="checkbox"/> Congestion	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Color change	<input type="checkbox"/> Confusion
<input type="checkbox"/> Runny nose (Rhinorrhea)	<input type="checkbox"/> Rapid heartbeat (Palpitations)	<input type="checkbox"/> Pale skin (Pallor)	<input type="checkbox"/> Decreased concentration
<input type="checkbox"/> Postnasal drip	GI (Gastrointestinal): <input type="checkbox"/> Negative	<input type="checkbox"/> Rash	<input type="checkbox"/> Dysphoric mood
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Abdominal distention	<input type="checkbox"/> Wound	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Dental problem	<input type="checkbox"/> Anal bleeding		<input type="checkbox"/> Nervous/anxious
<input type="checkbox"/> Drooling	<input type="checkbox"/> Blood in stool		<input type="checkbox"/> Self-injury
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Constipation		<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Suicidal ideas
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Nausea		Other: <input type="checkbox"/>
<input type="checkbox"/> Voice change	<input type="checkbox"/> Rectal pain		<input type="checkbox"/>
	<input type="checkbox"/> Vomiting		<input type="checkbox"/>

University of Kansas Medical Center
3901 Rainbow Blvd., Mail Stop 3010
Kansas City, KS 66160
Kansas University Physicians, Inc.

Recognizing the need for medical care for the patient whose name appears on this form, I do voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by the medical staff of Kansas University Physicians, Inc. and their assistants or designees as is necessary. I understand that, other than in the case of emergency treatment, I will have the opportunity to participate in the process by which decisions are made about the patient's care. I also understand that I will be asked to sign separate consent forms for the authorization of any non-routine procedures and treatments the patient might require.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of the examination or medical treatment of Kansas University Physicians, Inc.

I understand that Kansas University Physicians, Inc. has teaching responsibilities through its affiliation with the University of Kansas Medical Center and give my permission for the involvement of health care students, residents and other medical personnel for educational purposes. Furthermore, I give my consent that all tissues and specimens obtained, which would otherwise be discarded, may be used for research and/or teaching purposes when they do not identify me as the patient. I also understand that I may be asked to sign additional and separate authorization forms for clinical research and research using tissue specimens that will identify me as the patient.

I authorize Kansas University Physicians, Inc. to furnish requested information or excerpts from the patient's record to any insurance company, health plan or sponsoring agency who may be providing financial assistance for medical care (as well as any agents or review agencies necessary for processing any claim), including Medicare and Medicaid, for the purpose of obtaining payment; and to any physician, hospital, laboratory, radiological facility or other health care provider from which the patient has been referred or to which the patient is being referred as is necessary to support continuity of care. I understand that these medical records may include all information relative to the patient's physical condition, past and present, including the diagnosis and history of the patient's case, psychiatric history and alcohol or drug abuse information. I understand that the way Kansas University Physicians, Inc. may use this information is described under the Notice of Privacy Practices for KU Medical Center, of which I may request a copy at anytime.

I authorize payment of medical benefits to the Kansas University Physicians, Inc. for services provided to the patient. I also authorize payment of government benefits to Kansas University Physicians, Inc.

I accept full financial responsibility for services received by the patient which are not covered by government benefits or any type of insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Kansas University Physicians, Inc. at the time of services. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND AM AUTHORIZED TO CONSENT FOR MEDICAL CARE OF THE PATIENT NAMED BELOW.

Patient's Name: _____

Signature of Patient or Authorizing Person: _____

Signature of Witness: _____

X _____ Date _____

_____ Date _____

Relationship to Patient

Clinic

Authorization must be signed by the patient, by a parent if the patient is a minor, or by a guardian if the patient is incapacitated.