Cedar Valley Medical Specialists, P.C.

REGISTRATION FORM

(PLEASE PRINT)

Today's Date: _____

Your Pharmacy: _____

Address: _____

Patient Information (☐ VALIDATED ID ☐ PHOTO ID REFUSED ☐ NO PHOTO ID AVAILABLE)

Last name:	First:	MI:	Sex: ☐ M ☐ F
Nickname:	Birth date:	Age:	Soc. Sec. #:

Marital status:
☐ Single
☐ Married
☐ Divorced
☐ Legally Separated
☐ Widowed

Primary Language:
☐ English
☐ Spanish
☐ Bosnian
☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Declined
☐ Unknown

Race: _____
01 = Black, African American
02 = Asian
03 = White
08 = American Indian, Alaska Native
09 = Native Hawaiian, Other Pacific Islander
98 = Unknown
99 = Declined

Address:	PO Box:	City:	State:	ZIP Code:
Home phone: ( )	Cell Phone: ( )	Email Address:		
Referred by:	Family Doctor:			
Emergency Contact Name:	Relationship:	Phone: ( )		

Student Information: ☐ Not a Student ☐ Yes if yes, ☐ full-time ☐ part-time

College Name (If attending):

Employment Information: *(If employed fill out below)* Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐

Occupation:	Employer:	Employer phone:
Spouse's Name:	Employer:	

Who will be responsible for your account? ☐ **Self** (if self, skip to next section) ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other**

Name:	Soc. Sec.#	Phone:	
Address (if different):	City:	State:	Zip Code:
Employer:	Business Phone:		

Health Insurance Information (Please give your insurance card to the receptionist.)

Primary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

Secondary Insurance:

Insurance Company Name:	Group #:	Policy #:
Policy Holder:	Policy Holders Date of Birth:	Policy Holders S.S.#:
Insured's Employer:	Relationship to Patient:	

If Patient is under 18 years of age: *(and you have not provided the following information in the Health Insurance Section)*

Father's Name:		Mother's Name:	
Address:	Phone:	Address:	Phone:
Employer:		Employer:	

If this is a result of an accident or injury, please answer the following questions & complete accident/injury form.

Date of Accident or Injury:	Brief Description of Injury:

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialist's P.C. to release any medical information necessary to process my claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialist's P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize that a copy of this information to be as valid as the original.

Signature: _____ Date: _____

Cedar Valley Medical Specialists, P.C.
Patient Communication Form for Privacy Practices

Office/Specialty:_____ Date:_____

Our office notifies patients of upcoming appointments two (2) business days prior to appointment. Please indicate how you would prefer to receive this reminder.

☐ Phone Call to (____)_____ Cell/Home/Work (please circle)
☐ Text to (____)_____ Cell *Messaging and/or data rates may apply from your carrier for texts.*

Our office will make an effort to notify you of your test/lab/procedure/etc. results if necessary. You may instruct Cedar Valley Medical Specialists, P.C. as to the method of communication and who may and/or may not receive these communications.
Please Mark the Best Method of Communication

☐ Phone (____) _____Cell/Home/Work (please circle)

☐ Mailing Address _____

_____

_____

☐ Secure patient portal

I give my permission for the following **TO RECEIVE** my test/lab/procedure/etc. results, if necessary.

(The person/s below will only receive test results if patient is unavailable or unable to be reached).

Spouse (full name) _____ (Phone) _____

Child (full name) _____ (Phone) _____

Friend (full name) _____ (Phone) _____

Parent (full name) _____ (Phone) _____

Other (full name) _____ (Phone) _____

DO NOT give my personal Health Information to the following named person/persons.

(full name) _____ (Phone) _____

(full name) _____ (Phone) _____

Exceptions to this release: _____

I hereby acknowledge that I have been informed, that I may receive a copy of Cedar Valley Medical Specialists, P.C.'s Notice of Privacy Practices upon request.

☐ **Copy Provided** ☐ **I do not want a copy**

_____ _____ _____

Signature (Patient or Guardian) **Patient Printed Name** **Patient Date of Birth**

_____

Guardian's relationship to patient

CEDAR VALLEY
Center for Facial Plastic Surgery
A branch of CVMS
Trust your face to a facial plastic surgeon

Cedar Valley Medical Specialists
David J. Congdon, M.D., M.P.H., F.A.C.S.
Department of Otolaryngology
Center for Facial Plastic Surgery
2515 Cyclone Dr. Suite B
Waterloo, Iowa 50701
(319) 888-8044

CEDAR VALLEY
ENT and Sinus Center
A branch of CVMS
Advanced ENT and Sinus Solutions

Name:_____ **Birthdate:**_____ **Age:**_____
Height:_____ **Weight**_____

Referred by:_____ **Primary Physician:**_____

Reason for appointment:_____

Allergies:	YES	NO
None known	___	___
Penicillin	___	___
Sulfa	___	___
Local anesthetics	___	___
Codeine	___	___
Darvocet	___	___
Latex	___	___
IVP Dye	___	___

Other (list):_____

_____

Current Medications (include non-prescription):

_____
_____
_____
_____
_____
_____
_____
_____

Do you take blood thinners or ASPIRIN daily? ___Yes ___No

Active Problems/Medical History:

YES	NO	
___	___	Asthma
___	___	COPD/Emphysema
___	___	High Blood Pressure
___	___	Heart Disease (Angina/CHF/CAD)
___	___	Heart Attack
___	___	Irreg. Heart Beat/Pacemaker/Defibrillator
___	___	Kidney Disease
___	___	Thyroid Problems
___	___	Sleep Apnea
___	___	Sleep study done___(year)_____(location)
___	___	Hepatitis
___	___	Stroke
___	___	Seizure/Epilepsy
___	___	Diabetes (On insulin / On oral meds)
___	___	Skin Cancer (Type_____)
___	___	Other Cancer (Type_____)
___	___	Bowel Disease (Diverticulosis/ Crohns)
___	___	Chicken Pox / Measles / Mumps / Rubella
___	___	MRSA
___	___	Head and/or neck mass
___	___	Other:_____

Previous Surgery:

YES	NO	
___	___	Tonsil / Adenoid Removal
___	___	PE (Ear) Tubes
___	___	Septoplasty / Rhinoplasty
___	___	Sinus Surgery
___	___	Hernia
___	___	C-section
___	___	Colon
___	___	Breast
___	___	Bypass surgery / Stent Placement
___	___	Hysterectomy
___	___	Tubal ligation
___	___	D & C
___	___	Back/Neck
___	___	Appendix Removal
___	___	Gallbladder Removal
___	___	Skin Cancer Surgery
___	___	Other _____

Previous Hospitalizations:_____

_____

OVER

Family History (grandparents, parents, siblings):

YES	NO		RELATIONSHIP
___	___	Lung Disease	_____
___	___	Stroke	_____
___	___	Diabetes	_____
___	___	Tuberculosis	_____
___	___	Cancer-Type_____	_____
___	___	Epilepsy	_____
___	___	Heart Disease	_____
___	___	Rheumatoid arthritis	_____
___	___	High Blood Pressure	_____
___	___	Kidney Disease	_____
___	___	Bleeding Tendencies	_____

Social History:

Occupation_____

Marital Status:

___Married ___Widowed ___Single ___Divorced

Miscellaneous:

Have you ever had an unusual reaction to general or local anesthetic? ___Yes ___No

Explain_____

_____

_____

Have you ever had a blood or blood product transfusion? ___Yes ___No

Do you need to take antibiotics before having surgery or dental work done? ___Yes ___No

Do You Smoke? ___Yes ___No

Use Smokeless tobacco? ___Yes ___No

Ever smoked/used tobacco? ___Yes ___No

Exposed to second-hand smoke? ___Yes ___No

Alcohol? ___Yes ___No Amount _____

Caffeine? ___Yes ___No Amount_____

Review of Systems: Signs and / or symptoms you may have experienced recently.

YES	NO		YES	NO		YES	NO	
___	___	Unexplained Weight Gain	___	___	Stuffy Nose	___	___	Heartburn/indigestion
___	___	Unexplained Weight Loss	___	___	Bloody Noses	___	___	Anxiety/nervousness
___	___	Fever / Chills	___	___	Sinus Headaches	___	___	Rashes
___	___	Ear Pain	___	___	Runny nose	___	___	Changing skin lesions
___	___	New Hearing Loss	___	___	Post Nasal Drip	___	___	Shortness of Breath
___	___	Ringing in Ears	___	___	Snoring	___	___	Coughing Up Blood
___	___	Itching in Ears	___	___	Sore Throats	___	___	Chronic Cough
___	___	New Visual Changes	___	___	Difficulty Swallowing	___	___	Difficulty Urinating
___	___	Dry Eyes	___	___	Hoarseness	___	___	Heart Palpitations
___	___	Joint pain	___	___	Swollen lymph nodes	___	___	Other_____

Patient Signature_____ **Date**_____

Physician Signature_____ **Date**_____

_____ _____ _____ _____ _____