CEDAR VALLEY ASCENT
Allergy, Skin Cancer, ENT

Kenny D. Rodriguez, MD
Chalis M. Treloar, AuD
Jenna M. Niccolls, PA-C
Emily J. Clinton, ARNP
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Crystal A. Wilken, ARNP

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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:
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:	
Employer:			Business Phone:		
Health Insurance Information (Please give your insurance card to the receptionist.)					
Primary Insurance:					
Insurance Company Name:	Group #:		Policy #:		
Policy Holder:	Policy Holder's DOB:		Policy Holder's S.S. #:		
Insured's Employer:	Relationship to Patient:				
Secondary Insurance:					
Insurance Company Name:	Group #:		Policy #:		
Policy Holder:	Policy Holder's DOB:		Policy Holder's 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 a reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialists, P.C. to release any medical information necessary to process my claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialists, 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.

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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)*

☐ 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 _____

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Medical History

Name: _____ Birthdate: _____ Age: _____

Height: _____ Weight: _____

Referred by:_____ Primary Physician:_____

Reason for appointment: _____

Allergies	YES	NO	**Current Medications (include non-prescription):**
None Known	___	___	_____
Penicillin	___	___	_____
Sulfa	___	___	_____
Local Anesthetics	___	___	_____
Codeine	___	___	_____
Darvocet	___	___	_____
Latex	___	___	_____
IVP Dye	___	___	_____

Other (list): _____

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

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Medical History (cont.)

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 Symptoms: 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: _____

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Epworth Sleepiness Scale

Name: _____

DOB: _____

Date: _____

Please rate the likelihood of dozing off or falling asleep in the following situations. Or if you were in an encounter listed below, how do you feel you would respond?

0 Would never dose **1** Slight chance of dosing **2** Moderate chance of dosing **3** High chance of dosing

	CHANCE OF DOZING			
Sitting and reading or watching TV	0	1	2	3
Sitting inactive in a public place (theater, meeting, lecture)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon while circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
	Total Score			

- 0-10: Normal range of daytime sleepiness
- 11-14: Mild sleepiness
- 15-17: Moderate sleepiness
- 18 or higher: Severe sleepiness

When the score is greater than 10, this is an indication that you need to visit with a provider.

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Nasal Obstruction and Septoplasty Effectiveness Scale

Name: _____

DOB: _____

Date: _____

In the past month, how much of a problem were the following conditions for you?
Please circle your most accurate response.

	Not a problem	Very mild problem	Moderate problem	Fairly bad problem	Severe problem
Nasal Congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through my nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

NOSE Scoring (Multiply your total score x5): _____

- 5-25 Mild
- 30-50 Moderate
- 55-75 Severe
- 80-100 Extreme

Please review the scale score with your provider.

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Sino-Nasal Outcome Test (SNOT-22)

Name: _____

DOB: _____

Date: _____

Please rate the listed symptoms based on the last **two weeks.** These symptoms could be related to rhinosinusitis. This form will help us understand and rate your symptoms.

Please circle the number in each row to rate the severity of the problem.	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problems as bad as it can be		Most important items
1. Need to blow nose	0	1	2	3	4	5		
2. Nasal blockage (congestion)	0	1	2	3	4	5		
3. Sneezing	0	1	2	3	4	5		
4. Runny nose	0	1	2	3	4	5		
5. Cough	0	1	2	3	4	5		
6. Post-nasal discharge	0	1	2	3	4	5		
7. Thick nasal discharge	0	1	2	3	4	5		
8. Ear fullness	0	1	2	3	4	5		
9. Dizziness	0	1	2	3	4	5		
10. Ear pain	0	1	2	3	4	5		
11. Facial Pain/pressure	0	1	2	3	4	5		
12. Decreased sense of smell/taste	0	1	2	3	4	5		
13. Difficulty falling asleep	0	1	2	3	4	5		
14. Wake up at night	0	1	2	3	4	5		
15. Lack of good night's sleep	0	1	2	3	4	5		
16. Wake up tired	0	1	2	3	4	5		
17. Fatigue	0	1	2	3	4	5		
18. Reduced productivity	0	1	2	3	4	5		
19. Reduced concentration	0	1	2	3	4	5		
20. Frustrated/restless/irritable	0	1	2	3	4	5		
21. Sad								
22. Embarrassed								
TOTALS (each column)								

Please mark the most important items affecting your health maximum of **5 items.**

Grand Total Score (all columns together): _____

Dubuque
3315 John F Kennedy Rd.
Dubuque, IA 52002

Grundy Center
201 E. J Ave.
Grundy Center, IA 50638

Hiawatha
1560 Boyson Rd., Ste. D
Hiawatha, IA 52233

Independence
1600 1st St. East
Independence, IA 50644

Oelwein
2405 Rock Island Rd.
Oelwein, IA 50662

Waterloo
2515 Cyclone Dr, Ste. B
Waterloo, IA 50701

Waverly
1253 4th St. SW
Waverly, IA 50677

319-888-8044 | 319-349-8402