ENT

Bosco E. Noronha, M.D. PC

Department of Otolaryngology
& Head and Neck Surgery

Patient Registration Form

Last Name_____ **First Name**_____

Middle Name:_____ **Preferred Name**_____ **Maiden Name**_____

Date of Birth_____ **Social Security #**_____ **Male**_____ **Female**_____

Marital Status (please circle) Married Divorced Separated Single Widowed

Mailing Address: Street Name_____

Po Box_____ **or Appt #**_____

City_____ **State**_____ **Zip**_____ **County**_____

Mobile_____ **Mobile Phone Carrier**_____

Home phone_____ **Work phone**_____

E-Mail_____

Emergency Contact Person's Name & relationship _____ **Phone #**_____

Preferred Pharmacy (Primary)_____

Mail in Pharmacy_____

Primary Care Physician or Pediatrician_____

Were you referred? If yes by who? _____

Signature_____

Signature of Parent or Guardian (if Minor)_____ Date_____

1265 Wayne Ave • 119 Professional Center • Suite 100 • Indiana, PA 15701
Phone: 724-349-5440 • Fax: 724-349-7445

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No-Show, Late, & Cancellation Policy

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Bosco E. Noronha, M.D., P.C.'s goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification of at least 48 hours is required for scheduled procedure or special testing appointments due to the time and intensity necessary for these appointments which include: Videonystagmography (VNG) testing, Allergy testing, Audiometric testing or In-office procedure. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established patients:

a. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.

b. In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available.

c. **Patients who fail to show for any office visit appointment or did not notify the office of cancellation at least 24 hours before their scheduled appointment time will incur a No-Show or late cancellation fee of $40.00.**

d. **Patients who fail to show for any procedure or special testing appointment or did not notify the office of cancellation at least 48 hours before their scheduled appointment time will incur a No-Show or late cancellation fee of $60.00. These appointments would include VNG testing, Allergy Testing, Audiometric Testing or In-office Procedure. Fees will be charged the same day of Now Show or Late Cancellation!**

e. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Bosco E. Noronha, M.D., P.C.

III. New patients:

a. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.

d. In the event of three (3) documented No-Shows or "same-day cancellations," the patient may be subject to dismissal from Bosco E. Noronha, M.D., P.C.

Print Name Signature Date

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In order for our physicians to provide you with the highest quality of specialized care and an accurate assessment, it is necessary for you to complete the following forms:

Please PRINT

Last Name _____ First Name _____ Middle Initial _____

DOB ___/___/___ Home Phone _____ Cell Phone _____

Pharmacy Name _____ Pharmacy Phone _____

Mail Order Pharmacy _____ Mail order Pharmacy Phone _____

Family/PCP _____ Phone Number _____

Referring Physician _____ Phone Number _____

Medication Allergies: Reaction Type:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Recently, have you had any of the following symptoms or problems?
Please mark ALL that apply:

Constitutional
- ☐ Weakness or Fatigue
- ☐ Recent Weight Loss

Eyes
- ☐ Blurred vision
- ☐ Double vision

Ear, Nose, Mouth, Throat
- ☐ Trouble hearing
- ☐ Difficulty swallowing

Gastrointestinal
- ☐ Heartburn or Acid Reflux
- ☐ Frequent use of atnacids

Genitourinary
- ☐ Kidney problems
- ☐ Bladder problems

Musculoskeletal
- ☐ Muscle problems
- ☐ Joint stiffness/arthritis

Cardiovascular
- ☐ Heart trouble
- ☐ High blood pressure

Integumentary
- ☐ Skin cancer/skin condition
- ☐ Skin lesion/rash

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ Shortness of breath

FIRST & LAST NAME _____

Neurological
- ☐ Headaches
- ☐ Blackouts or fainting

Hematologic
- ☐ Easy bruising or bleeding
- ☐ Anemia or B12 deficiency

Endocrine
- ☐ Thyroid trouble
- ☐ Diabetes

Psychiatric
- ☐ Nervousness or increased stress
- ☐ Excessive moodiness or worry

Allergic
- ☐ Hay fever or dust/mold allergy
- ☐ Food sensitivity

Social History:

Tobacco Use: Yes No Quit Passive
Packs Per Day : _____ # of Years: _____
Age Started: _____ Age Quit: _____
Type: (please circle) Cigarettes Pipe Cigars Snuff Chew
Alcohol Use: Yes No Average Drinks per day: _____
Drug Use: Yes No Type: IV Drugs Marijuana Cocaine Meth Heroin
Caffeine Use: Cofeee Tea #Cups per day _____ Soda/Pop: #per day _____
Exercise: Yes No #Days per week: _____

MEDICATION LIST:

Prescription (ie Coumadin)	Dose (ie 2mg)	How often Taken (ie 2 tabs twice a day)	Prescribing doctor (ie Dr. Bosco Noronha)

Over the Counter Medications:

Over the Counter (ie Vitamin D3)	Dose (ie 1000 IU)	How often taken (ie Once daily)

FIRST & LAST NAME _____

Past Medical History:

Yes		Yes	
	Lung Disease		Panic Attacks
	Heart Disease		Anxiety Disorder
	Deep Vein Thrombosis		Depression
	High Blood Pressure		Cancer
	Stroke or TIA		Head/Neck Cancer
	Diabetes		Head Trauma
	Thyroid Problems		History of Fall
	GERD/Reflux		Seizure
	Kidney Problems		Macular Degeneration
	Arthritis		Glaucoma
	Use alerternative medicine		Migraine headaches

Other Medical History: _____

_____

Surgical History:

Yes		Yes	
	Adverse reaction to anesthesia		Facial plastic surgery
	Tonsillectomy/adenoidectomy		Spine surgery
	Head and neck surgery		Sino-nasal surgery
	Thyroid surgery		Sleep apnea surgery
	Ear surgery		

Other Surgical History: _____

_____

Family Medical History:

Condition	**Family Member**
Problems with anesthesia	_____
Bleeds easily	_____
Cancer, Esophagus	_____
Cancer, Head or Neck	_____
Cancer, Lung	_____
Cancer, Other	_____
Cancer, Thyroid	_____
Dizziness	_____
Epilepsy	_____
Hearing Loss	_____
Migraine Headaches	_____
Sleep Apnea	_____
Stroke	_____
Heart Condition/Attack	_____