

Advanced ENT

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Today's Date: _____

Referring Physician: _____

A copy of your Insurance card(s) and Photo I.D. will be required before the initial visit.

PATIENT INFORMATION

Patient's Name (First/Middle/Last): _____ Sex: Male/ Female

Mailing Address: _____ Physical Address: _____

City: _____ State/Zip: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Marital Status: S / M / D / W / Sep

What is your occupation and Employer? _____

Name of Parent(s) (If patient is a minor): _____

Emergency Contact (Name & Phone): _____

INSURANCE INFORMATION

Are you covered by: Insurance ___ Medicaid ___
Medicare ___ Third Party ___ Workman's Comp ___

PRIMARY INS.

Company Name: _____

Insured Party's name: _____

Insured D.O.B.: _____

Insured SSN: _____ - _____ - _____

Group #: _____ I.D.#: _____

ADDITIONAL INS.

Company Name: _____

Insured Party's name: _____

Insured D.O.B.: _____

Insured SSN: _____ - _____ - _____

Group #: _____ I.D.#: _____

I do hereby authorize Advanced ENT to release information to my insurance company named above to expedite payment. I understand that I am responsible for all charges regardless of insurance.

Any past due account that is forwarded for collections will be subject to additional fees.

Patient (or Legal Guardian) Signature: _____

MEDICAL HISTORY

What brings you to our office today? _____

Past Medical History: _____

Past Surgical History: _____

Do you have any family health problems? _____

Do you smoke? (Y / N) How much? _____ Do you drink alcohol? (Y / N) How much? _____

Current Medications: _____

Drug Allergies: _____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE EXPERIENCING:

Eyes: Blurred Vision / Double Vision / Itchy Eyes / Discharge

Ears: Hearing Loss / Ringing / Pain / Itching / Dizziness / Fullness

Nose: Loss of Smell / Bleeding / Discharge / Obstruction / Itching / Post-Nasal Drip

Throat/ Neck: Sore Throat / Hoarseness / Stiffness / Pain

Head: Headaches / TMJ Pain

Lungs: Coughing / Wheezing / Chest Congestion

Heart: Chest Pain / Fainting / Ankle Swelling

GI: Nausea / Vomiting / Heartburn / Diarrhea

General: Fatigue / Fever / Chills / Night Sweats

Is there anything else you feel Dr. Rosane should know? _____

PARENT / GUARDIAN INFORMATION

Mother / Guardian Name: _____

Mailing Address (if different from patient's): _____

Physical Address (if different from patient's): _____

Phone: _____ **Work:** _____ **Cell:** _____

Date of Birth: _____ **SSN:** _____

Employer: _____

Occupation: _____

Father / Guardian Name: _____

Mailing Address (if different from patient's): _____

Physical Address (if different from patient's): _____

Phone: _____ **Work:** _____ **Cell:** _____

Date of Birth: _____ **SSN:** _____

Employer: _____

Occupation: _____
