Virgin Islands
Ear, Nose & Throat
Adam M. Shapiro, MD, F.A.C.S.
Joseph Ryan Smolarz, MD, F.A.C.S.
Gavin M. Gassen, MD

Patient Registration Form

Patient name - First _____ Middle initial _____ Last _____

Please indicate, as required by the Federal Affordable Care Act:

Race ○ American Indian/Alaska Native ○ Asian ○ Black/African-Amer. ○ Native Hawaiian ○ White ○ Refused to report/unreported

Ethnicity ○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Refused to report/unreported

Language ○ English ○ Spanish ○ Other _____

Gender ○ M ○ F Date of birth _____ Email address _____

Employer _____ Position _____ Social Security _____

Home phone _____ Work phone _____ Cell phone _____

Appointment with _____ Reason for visit _____

Physical Address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Provide two (2) emergency contacts (if patient is a child, please provide parent or legal guardian info):

Contact 1 - Name _____ Relationship to patient _____

Contact 1 - Home phone _____ Work phone _____ Cell phone _____

Contact 2 - Name _____ Relationship to patient _____

Contact 2 - Home phone _____ Work phone _____ Cell phone _____

Reason for Visit _____

Tobacco use? ○ yes ○ no Have you ever? ○ yes ○ no How much _____

Smoke Exposure ○ yes ○ no Past? ○ yes ○ no How long _____

Alcohol Use ○ yes ○ no Drinks per day _____

Medications you are taking:

Medication name _____ Reason _____

Medication name _____ Reason _____

Medication name _____ Reason _____

Medication name _____ Reason _____

List any allergies to medications _____

List any health problems _____

List any past surgeries _____

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Patient Registration Form

If you get a prescription during your visit which pharmacy do you want it sent to?

Pharmacy _____ Location _____

Family History

Mother ○ Living ○ Deceased Age/cause of death _____

Father ○ Living ○ Deceased Age/cause of death _____

Siblings # Living _____ # Deceased _____ Age/cause of death _____

Children # Living _____ # Deceased _____ Age/cause of death _____

Illness	**Which Relative/Age of Onset**
❑ Diabetes/Sugar	
❑ Hypertension/Blood Pressure	
❑ Stroke	
❑ Heart Disease	
❑ Cancer (list what type)	
❑ Sleep Disorder	
❑ Allergies	
❑ Hearing Loss	
❑ Dizziness	
❑ Bleeding/Bruising	
❑ Other	

How did you hear about our office? _____

If referred by physician, please list their name _____