NORTHEASTERN VERMONT REGIONAL HOSPITAL

Welcome to North Country Otolaryngology & Audiology!

_____has a scheduled appointment with_____

On _____at _____: _____am/pm

Welcome to our practice and thank you for choosing our providers to contribute in your healthcare. We are looking forward to meeting you and participating in your care.

Our office is open Monday through Friday from 8:00am-4:30pm.

We are located at 1080 Hospital Drive Suite #5, St. Johnsbury, VT 05819 in the Richard H. Bloch Building on the NVRH Campus. Exit 22 on I-91.

Please fill out the enclosed forms and bring them with you to your appointment.

Instructions for your appointment:

- Arrive 10 minutes early to check in
- Bring your insurance cards and present them upon checking in
- Copayments and self-insured (self-pay) visit payments are expected to be paid at the time of service

Thank you for taking the time to read about our practice. By providing the enclosed documentation completed at check-in, this will allow us to provide accurate, efficient, and confidential service upon your arrival to our practice.

If you have any questions please reach out and call (802) 748-5126 we are here to help! Alternatively, visit our website at www.nvrh.org/ear-nose-throat-otolaryngology for more information.

Sincerely,
The Staff at North Country Otolaryngology & Audiology

Some important things to know about **North Country Otolaryngology & Audiology:**

Patient Appointment Reminders: NVRH uses an automated appointment reminder system, called Artera. You can expect to receive a reminder phone call or text from our office prior to your appointment for confirmation, generally 24 - 48 hours in advance of your appointment.

Cancellations/Reschedules: We ask that you contact the office at least 24 hours in advance, if you need to cancel your appointment. When you fail to cancel a visit, you prevent that time from being given to another patient who needs care. We understand that circumstances may arise in which you are unable to give at least a 24-hour notice, but please contact the office as soon as you can.

No Show Policy: When you have a scheduled appointment that you do not attend, this is considered a "no-show". As a new patient, it is important to attend your New Patient Appointment. If you no-show 3 New Patient Appointments, then we will no longer schedule you an appointment to establish care with us, and you will need to seek care elsewhere. Once established with the practice, 3 failures to attend a scheduled visit, without prior notification, may result in dismissal from the practice. A copy of our No-Show Policy can be found with our Termination Policy on our website.

Late Arrival Policy: If you are more than 15 minutes late for an appointment, you may need to reschedule. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available, see another provider or reschedule. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Prescription Refills: We ask that you contact the office regarding medication refills at least 72 hours in advance to allow sufficient time for your provider to receive and respond to your request before you run out of your medication.

Patient Portal: Patients with a MyPortal account through NVRH can expect to receive appointment notifications through the portal. The portal is available for communication with your care team, submitting medication refill requests, reviewing your records, appointments and paying your bills.

Patient Surveys: We believe giving patients an opportunity for feedback is important. NVRH uses a service called Press Ganey. You may receive a survey via mail, email, or text. Thank you in advance for letting us know how we are doing.

Translation Services: If you require a translator, please let us know in advance of your appointment and we will arrange for an interpreter.

We thank you for allowing us to participate in your healthcare and hope that the above information will assist you in obtaining prompt and convenient medical care.

North Country Otolaryngology & Audiology
Deane E. Rankin M.D
Patrick M. Fitzpatrick D.O
Britney Bigelow FNP-C
Danny Ballentine PA-C
1080 Hospital Drive Suite 5, St Johnsbury, VT 05819

Today's Date _____ **Preferred Name:** _____

_____ _____ _____ _____ _____
Last Name **First Name** **Middle Initial** **Age** **DOB**

_____
Occupation **Birth Sex:** Male / Female **Legal Sex:** Male / Female / Non-Binary / Other

_____ _____ _____
Primary Care Provider **Pharmacy Name and Town** **Referring Provider**

Chief Complaint: What symptoms are you having that bring you to visit?

_____

Medications: List below the medications you are taking. Include prescriptions, and other medicines such as aspirin, vitamins, cold medications, etc. *(Please attached or provide a list if it exceeds the space below)*

Name Amount How often

_____
_____
_____

Allergies: Are you allergic to any medications? **Yes** **No**
If Yes, which ones? _____
_____

Past Medical History:

Have you had any serious injury? Yes No _____
If yes, please explain

Have you ever had any ear surgery? Yes No _____
If yes, what type and when?

Have you ever had any other type of surgery? Yes No _____
If yes, what type and when?

Do you have any major illnesses? Yes No _____
Please explain:

Family History: What medical problems run in your family?

Father: _____
Mother: _____
Other: _____

Social History:

Do you smoke?	Yes	No	How many cigarettes per day? _____	How long? _____
Did you smoke?	Yes	No	How long? _____	Quit date? _____
Do you drink alcohol?	Yes	No	How many drinks per day? _____	How long? _____

Have you had problems with alcoholism?	Yes	No
Have you had problems with drug use?	Yes	No
Do you drink caffeine?	Yes	No

Review of Systems:

Have you ever been treated for any of the following? **Please check all that apply.**

Fatigue	_____	Ulcer	_____	Thyroid Problems	_____
Fever	_____	Blood in Stool	_____	Pituitary Problems	_____
Weight Loss	_____	Colitis	_____	Bleeding Disorder	_____
Snoring	_____	Prostate Problems	_____	Anemia	_____
Hoarseness	_____	Kidney Stones	_____	Lymphoma	_____
Glaucoma	_____	Hepatitis	_____	Venereal disease	_____
Double Vision	_____	Liver trouble	_____	AIDS/HIV	_____
Other eye problems	_____	Gall bladder problems	_____	Cancer	_____
Loss of taste	_____	Kidney infection	_____	Blood transfusion	_____
Loss of smell	_____	Blood in urine	_____	Seizures	_____
Sinus trouble	_____	Bladder infection	_____	Loss of consciousness	_____
Difficulty swallowing	_____	Arthritis	_____	Head injury/concussion	_____
High Blood Pressure	_____	Fibromyalgia	_____	Multiple sclerosis	_____
Heart Failure	_____	Bone disease	_____	Nervous Disorder	_____
Chest pain/Angina	_____	Joint disease	_____	Anxiety	_____
Heart Attack	_____	Back problems	_____	Depression	_____
Ankle/Foot swelling	_____	Breast (lump/tumor)	_____	Frequent infections	_____
Shortness of breath	_____	Rashes	_____	Environmental allergies	_____
High cholesterol	_____	Eczema	_____	Hay fever	_____
Cough	_____	Headaches	_____	Reflux	_____
Diabetes	_____	Meningitis	_____	Sleep apnea	_____

Please add details:

_____

_____

I acknowledge that the information stated above is true and complete:

_____ _____

Patient/Guardian Signature Date

"Please help us make your check-in process smoother, faster, and more confidential; by filling out the below demographic information ahead of time and bringing it to your appointment." - Thank You

Patient Registration Information

Patient's Name: _____ *(legal name: last, first and middle initial)*

Preferred Name: _____

Birth Sex: Male / Female **Legal Sex:** Male/ Female / Non-Binary / Other **Date of birth:** _____/_____/_____

Primary Phone #: _____ Home / Cell / Work May we leave a message? Yes / No

Secondary Phone #: _____ Home / Cell / Work May we leave a message? Yes / No

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Email Address: _____

Preferred Language: _____

Marital Status: *Married Single Divorced Widowed Legally Separated Life Partner Civil Union Unknown*

Veteran Status: Yes / No

Race: *American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Island White*

Ethnicity: *Hispanic Not Hispanic Decline to provide*

Person to Notify: _____ **Relationship To Patient:** _____

Phone#: (_____) _____ - _____

Patient's Primary Care Provider (PCP) (Family Doctor): _____

Pharmacy Name and Location: _____