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 15 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:**

Littleton Regional Healthcare (LRH) Collaboration: If your appointment is to see Dr. Fitzpatrick or Danny Ballentine, PA., you may receive an additional form. Patients seen by one of these providers will be booked in LRH's medical record as well. They have the potential to be seen in either location.

Patient Appointment Reminders: NVRH uses an automated appointment reminder system, called WELL. 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 you 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.

NORTHEASTERN VERMONT REGIONAL HOSPITAL

LITTLETON REGIONAL HEALTHCARE

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 **Gender Identity:** Male / Female

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 illnesses? **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 **Gender Identity:** Male/ Female **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: ______________________________________ Sate: _________________ 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*

Emergency Contact / Person to Notify: ____

Phone#: _ (_______) _________ - ___________

Patient’s Primary Care Provider (PCP) (Family Doctor): ____

Pharmacy Name and Location: ____

8/2021