

EAR, NOSE & THROAT ASSOCIATES OF EAST TEXAS

Adult Patient Information Sheet

Today's Date _____ DOB _____ SS # _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Sex: **M** **F** Marital Status: **Single** **Married** **Divorced** **Widowed**
 (Please Circle) (Please Circle)

Preferred Language _____ Race _____ Ethnicity _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ E-mail _____

Patient's Employer _____ Work Phone # _____

Spouse's Name _____ Spouse's DOB _____ Spouse's SS # _____

Spouse's Employer _____ Work Phone # _____

Please list all insurance companies with which we are to file your claim.		
INSURANCE CO	POLICY HOLDER	DOB
Primary:		
Secondary:		
Tertiary:		

Copy of card(s) will be obtained

Referred By _____

Patient's Primary Physician _____ Phone # _____

Pharmacy _____ Phone # _____

Emergency Contact (Not at your address) _____ Relationship _____

Emergency Contact Address _____ Phone # _____

List other family members seen in our office _____

EAR, NOSE & THROAT ASSOCIATES OF EAST TEXAS
Adult Patient Information Sheet (Page 2)

Initial

AUTHORIZATION FOR TREATMENT – I voluntarily consent to receive health care services deemed necessary provided by Ear, Nose & Throat Associates of East Texas. I understand that this consent to treatment will be valid and remain in effect unless revoked by me in writing.

Initial

PAYMENT FOR SERVICES – Payment for services, including co-payment and deductible amounts, is due at the time services are rendered. Our failure to collect these amounts may be a violation of our contract with your insurance company. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility with your insurance company.

We accept cash, checks, MasterCard, VISA, Discover and American Express.

Returned checks, balances over 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees.

Initial

INSURANCE – If you have medical insurance in which our office is a contracted provider, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with a copy of your insurance card.

We will file claims for your covered medical services to your insurance company. However, we expect payment of all services within 90 days. It may become necessary for you to pay your account in full if your insurance company fails to pay us for services within 90 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals and authorization requirement, and further understand that you will be responsible for all deductibles, non-reimbursable fee or fees for services not covered by my health care plan. We will, however, assist you to insure all plan requirements are met.

If you are a member of a managed care health plan:

- We are required to collect your copayment at the time of service. We cannot bill your health plan for your copayment.
- If a referral from your primary care physician (PCP) is required and we do not have this number at the time of service, your benefits might not be paid at all, or paid at a reduced rate. You would then be responsible for the entire amount of charges.

Initial

INSURANCE ASSIGNMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize Ear, Nose & Throat Associates of East Texas to disclose necessary information to any third-party payer or to the following parties when requested for the purpose stated herein; to any physicians for the purpose of providing continuing professional care and to any insurance company or third-party payer (or their agent) for the purpose of obtaining payment to Ear, Nose & Throat Associates of East Texas for services provided. Ear, Nose & Throat Associates of East Texas, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

In consideration of services rendered or to be rendered, I hereby assign and transfer to Ear, Nose & Throat Associates of East Texas any benefits payable on my behalf for services rendered.

Initial

NO SHOW AND CANCELLATION POLICY – At ENT Associates of East Texas, we care about your health. One of the ways we can meet your healthcare needs is to provide appointments with our physicians in a timely manner. ENT Associates asks that you notify the receptionist **at least four (4) hours in advance** when you are unable to keep your scheduled appointment.

If you are unable to keep your scheduled appointment, we want to remind you of the importance of follow-up treatments, as indicated by your physician if your condition has not improved.

A missed appointment will be rescheduled once upon request. A second missed appointment within 12 months will result in a no-show fee of \$25.00, which is not covered by insurance. You will not be rescheduled until this fee is paid in full. Three missed appointments within 12 months may result in dismissal from our practice.

Initial

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY RIGHTS – I have reviewed Ear, Nose & Throat Associates of East Texas' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Legal Guardian

Date

Patient Name: _____ DOB: _____ Date of initial visit: _____

Age: _____ Height: _____ Weight: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Reason for today's visit: _____

When did the problem start? _____

Did anything specific cause the problem to begin? _____

What makes it better? _____ Worse? _____

DRUG ALLERGIES – Please list all drug allergies and type of reaction:

I have no drug allergies

Drug	Reaction	Drug	Reaction

SURGICAL – Please list all past surgeries with year surgery performed.

I have no history of surgeries

Surgical Procedure	Date	Surgical Procedure	Date

CURRENT MEDICATIONS – Please list all medications you currently take.

I am not currently on any medications

Current Medications	Dose	Frequency	Current Medications	Dose	Frequency

NONPRESCRIPTION MEDICATIONS – Please list all nonprescription medications including supplements and ASPIRIN.

I am not taking any nonprescription medications

Nonprescription	Dose	Frequency	Nonprescription	Dose	Frequency

If you are female, when was the first day of your last menstrual period? _____

If this form is completed by anyone other than the patient, please write the name and relationship.

Name: _____ Relationship to Patient: _____

I certify that this information is accurate to the best of my knowledge. I will notify you if any changes occur.

Signature: _____ Date: _____

Please check all that apply

SOCIAL HISTORY		SERIOUS ILLNESS/HOSPITAL HISTORY	
<input type="checkbox"/>	Social History Reviewed	<input type="checkbox"/>	Past Medical History Reviewed - No Change
<input type="checkbox"/>	Alcohol - Denies	<input type="checkbox"/>	Patient Denies Serious Illnesses
<input type="checkbox"/>	Alcohol - Heavy	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Alcohol - Occasionally	<input type="checkbox"/>	Angina
<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Drug Use - Denies	<input type="checkbox"/>	Arrhythmia
<input type="checkbox"/>	Drug Use - Positive History	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Drug Use - Positive IV Drug Abuse	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Employment: Disabled	<input type="checkbox"/>	Bleeding Disorders
<input type="checkbox"/>	Employment: Full Time	<input type="checkbox"/>	Breathing Problems
<input type="checkbox"/>	Employment: Part Time	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Employment: Retired	<input type="checkbox"/>	Chest Pain/Heart Attack
<input type="checkbox"/>	Employment: Self-Employed	<input type="checkbox"/>	Chronic Bronchitis
<input type="checkbox"/>	Employment: Student	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	Employment: Unemployed	<input type="checkbox"/>	COPD
<input type="checkbox"/>	Employment: Works at Home	<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	Marital Status: Divorced	<input type="checkbox"/>	Cystic Fibrosis
<input type="checkbox"/>	Marital Status: Married	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Marital Status: Single	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Marital Status: Widowed	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Other	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Smokeless Tobacco	<input type="checkbox"/>	Gastroesophageal Reflux/Ulcers
<input type="checkbox"/>	Smoking: Current Some Day Smoker	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Smoking: Former Smoker	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Smoking: Never Smoked	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Smoking: Smoker, Current Status Unknown	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Smoking: Unknown If Ever Smoked	<input type="checkbox"/>	Heart Murmur
FAMILY HISTORY		<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Family History Reviewed	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	Adopted	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	Bleeding / Platelet Disorder	<input type="checkbox"/>	Ménière's Disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Obstructive Sleep Apnea
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Peripheral Vascular Disease
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Pulmonary Embolism
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Sarcoidosis
<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Obstructive Sleep Apnea	<input type="checkbox"/>	Sjögren's Syndrome
<input type="checkbox"/>	Other	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Problems With Anesthesia	<input type="checkbox"/>	Trigeminal Neuralgia
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Vasculitis
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Vertigo
		<input type="checkbox"/>	Von Willebrand's Disease

Please check all that apply

REVIEW OF SYSTEMS	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mouth/Throat: Lesions
<input type="checkbox"/> Ears: Balance Disturbance	<input type="checkbox"/> Mouth/Throat: Lump/Mass
<input type="checkbox"/> Ears: Blood In The Ear	<input type="checkbox"/> Mouth/Throat: Mouth Sores
<input type="checkbox"/> Ears: Drainage	<input type="checkbox"/> Mouth/Throat: Recurrent Strep
<input type="checkbox"/> Ears: Ear Infections	<input type="checkbox"/> Mouth/Throat: Swollen Tonsils
<input type="checkbox"/> Ears: Ear Pain	<input type="checkbox"/> Mouth/Throat: Tonsillitis
<input type="checkbox"/> Ears: Failed Hearing Test	<input type="checkbox"/> Mouth/Throat: Trach
<input type="checkbox"/> Ears: Failed Hearing Test At School	<input type="checkbox"/> Mouth/Throat: Voice Change
<input type="checkbox"/> Ears: Fluid	<input type="checkbox"/> Musculoskeletal: Arm or Leg Weakness
<input type="checkbox"/> Ears: Hearing Loss	<input type="checkbox"/> Musculoskeletal: Arthritis
<input type="checkbox"/> Ears: Hole In Eardrum	<input type="checkbox"/> Musculoskeletal: Back Pain
<input type="checkbox"/> Ears: Injury	<input type="checkbox"/> Musculoskeletal: Joint Pain or Swelling
<input type="checkbox"/> Ears: Noise Exposure	<input type="checkbox"/> Musculoskeletal: Leg or Arm Pain
<input type="checkbox"/> Ears: Ringing in Ears	<input type="checkbox"/> Musculoskeletal: Lupus
<input type="checkbox"/> Ears: Sudden Hearing Loss	<input type="checkbox"/> Neck: Lump/Mass
<input type="checkbox"/> Ears: Wears Hearing Aids	<input type="checkbox"/> Neck: Pain
<input type="checkbox"/> Endocrine: Excess Thirst or Urination	<input type="checkbox"/> Neck: Swollen Glands
<input type="checkbox"/> Endocrine: Glandular or Hormonal Problems	<input type="checkbox"/> Neck: Thyroid Nodules
<input type="checkbox"/> Eyes: Blind	<input type="checkbox"/> Neuro: Coordination Loss
<input type="checkbox"/> Eyes: Glaucoma	<input type="checkbox"/> Neuro: Disorientation
<input type="checkbox"/> Eyes: Infections	<input type="checkbox"/> Neuro: Double or Blurred Vision
<input type="checkbox"/> Eyes: Injuries	<input type="checkbox"/> Neuro: Face Weakness
<input type="checkbox"/> Face: Numb/Weak	<input type="checkbox"/> Neuro: Fainting Spells
<input type="checkbox"/> Gastrointestinal: Heartburn/Indigestion	<input type="checkbox"/> Neuro: Head Trauma
<input type="checkbox"/> Gastrointestinal: Hepatitis	<input type="checkbox"/> Neuro: Headaches
<input type="checkbox"/> Gastrointestinal: Jaundice	<input type="checkbox"/> Neuro: Memory Loss
<input type="checkbox"/> Gastrointestinal: Liver Disease	<input type="checkbox"/> Neuro: Migraines
<input type="checkbox"/> Gastrointestinal: Reflux	<input type="checkbox"/> Neuro: Seizures
<input type="checkbox"/> General: Fever	<input type="checkbox"/> Neuro: Speech Difficulty
<input type="checkbox"/> General: Night Sweats	<input type="checkbox"/> Neuro: Stroke
<input type="checkbox"/> General: Sleep Apnea	<input type="checkbox"/> Nose: Allergies
<input type="checkbox"/> General: Weight Loss	<input type="checkbox"/> Nose: Broken
<input type="checkbox"/> Genitourinary: Frequent Urination	<input type="checkbox"/> Nose: Fracture
<input type="checkbox"/> Genitourinary: Urinary Tract Infections	<input type="checkbox"/> Nose: Hole In The Septum
<input type="checkbox"/> Heart: Feet Swelling	<input type="checkbox"/> Nose: Inability To Smell
<input type="checkbox"/> Heart: Heart Attack	<input type="checkbox"/> Nose: Nasal Blockage
<input type="checkbox"/> Heart: Heart Murmur	<input type="checkbox"/> Nose: Nasal Congestion
<input type="checkbox"/> Heart: High Cholesterol	<input type="checkbox"/> Nose: Nasal Drainage
<input type="checkbox"/> Heart: Irregular Pulse	<input type="checkbox"/> Nose: Nosebleeds
<input type="checkbox"/> Hematologic/Lymphatic: Anemia	<input type="checkbox"/> Nose: Odor
<input type="checkbox"/> Hematologic/Lymphatic: Easy Bruising or Bleeding	<input type="checkbox"/> Nose: Pain
<input type="checkbox"/> Hematologic/Lymphatic: Hemophilia	<input type="checkbox"/> Nose: Polyp
<input type="checkbox"/> Hematologic/Lymphatic: Persistent Swollen Glands/Lymph Nodes	<input type="checkbox"/> Nose: Postnasal Drip
<input type="checkbox"/> Lungs: Chronic Cough	<input type="checkbox"/> Nose: Sinus Headaches
<input type="checkbox"/> Lungs: COPD	<input type="checkbox"/> Nose: Sinus Problems
<input type="checkbox"/> Lungs: Coughing Up Blood	<input type="checkbox"/> Nose: Snoring
<input type="checkbox"/> Lungs: Pneumonia	<input type="checkbox"/> Nose: Sores
<input type="checkbox"/> Lungs: Positive TB Test	<input type="checkbox"/> Other
<input type="checkbox"/> Lungs: Shortness of Breath	<input type="checkbox"/> Psychiatric: Anxiety
<input type="checkbox"/> Mouth/Throat: Cancer	<input type="checkbox"/> Psychiatric: Depression
<input type="checkbox"/> Mouth/Throat: Dental Problems	<input type="checkbox"/> Psychiatric: Other Psychiatric Disorder
<input type="checkbox"/> Mouth/Throat: Difficulty Swallowing	<input type="checkbox"/> Skin: Rash
<input type="checkbox"/> Mouth/Throat: Enlarged Tonsils	<input type="checkbox"/> Skin: Skin Disease