# EAR, NOSE & THROAT ASSOCIATES OF EAST TEXAS
## Child Patient Information Sheet

Today's Date | DOB | SS #

Patient's Last Name | First Name | Middle Initial | Sex: **M** **F** **(Please Circle)**

Preferred Language | Race | Ethnicity

Address | City | State | Zip Code

E-mail | Home Phone # | Cell Phone #

Mother's/Guardian's Name | Mother's DOB | Mother's SS #

Home Phone # **(If Different)** | Mother's Employer Name & Address | Mother's Work Phone #

Father's/Guardian's Name | Father's DOB | Father's SS #

Home Phone # **(If Different)** | Father's Employer Name & Address | Father's 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

***Additional Information on Page 2***

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

Initial **AUTHORIZATION FOR TREATMENT** – I voluntarily consent for my child 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 | |
|---|---|
| ❑ | Social History Reviewed |
| ❑ | Alcohol - Denies |
| ❑ | Alcohol - Heavy |
| ❑ | Alcohol - Occasionally |
| ❑ | Caffeine |
| ❑ | Drug Use - Denies |
| ❑ | Drug Use - Positive History |
| ❑ | Drug Use - Positive IV Drug Abuse |
| ❑ | Employment: Disabled |
| ❑ | Employment: Full Time |
| ❑ | Employment: Part Time |
| ❑ | Employment: Retired |
| ❑ | Employment: Self-Employed |
| ❑ | Employment: Student |
| ❑ | Employment: Unemployed |
| ❑ | Employment: Works at Home |
| ❑ | Marital Status: Divorced |
| ❑ | Marital Status: Married |
| ❑ | Marital Status: Single |
| ❑ | Marital Status: Widowed |
| ❑ | Other |
| ❑ | Smokeless Tobacco |
| ❑ | Smoking: Current Some Day Smoker |
| ❑ | Smoking: Former Smoker |
| ❑ | Smoking: Never Smoked |
| ❑ | Smoking: Smoker, Current Status Unknown |
| ❑ | Smoking: Unknown If Ever Smoked |

| FAMILY HISTORY | |
|---|---|
| ❑ | Family History Reviewed |
| ❑ | Adopted |
| ❑ | Allergies |
| ❑ | Asthma |
| ❑ | Autoimmune Disease |
| ❑ | Bleeding / Platelet Disorder |
| ❑ | Cancer |
| ❑ | Congestive Heart Failure |
| ❑ | Diabetes |
| ❑ | Hearing Loss |
| ❑ | Heart Attack |
| ❑ | Heart Disease |
| ❑ | High Blood Pressure |
| ❑ | Malignant Hyperthermia |
| ❑ | Obstructive Sleep Apnea |
| ❑ | Other |
| ❑ | Problems With Anesthesia |
| ❑ | Seizures |
| ❑ | Thyroid Disease |
| ❑ | Tuberculosis |

| SERIOUS ILLNESS/HOSPITAL HISTORY | |
|---|---|
| ❑ | Past Medical History Reviewed - No Change |
| ❑ | Patient Denies Serious Illnesses |
| ❑ | Anemia |
| ❑ | Angina |
| ❑ | Anxiety |
| ❑ | Arrhythmia |
| ❑ | Arthritis |
| ❑ | Asthma |
| ❑ | Bleeding Disorders |
| ❑ | Breathing Problems |
| ❑ | Cancer |
| ❑ | Chest Pain/Heart Attack |
| ❑ | Chronic Bronchitis |
| ❑ | Congestive Heart Failure |
| ❑ | COPD |
| ❑ | Coronary Artery Disease |
| ❑ | Cystic Fibrosis |
| ❑ | Depression |
| ❑ | Diabetes |
| ❑ | Emphysema |
| ❑ | Epilepsy |
| ❑ | Gastroesophageal Reflux/Ulcers |
| ❑ | Glaucoma |
| ❑ | Hearing Loss |
| ❑ | Heart Attack |
| ❑ | Heart Disease |
| ❑ | Heart Murmur |
| ❑ | Hepatitis |
| ❑ | HIV Positive |
| ❑ | Hypertension |
| ❑ | Kidney Disease |
| ❑ | Liver Disease |
| ❑ | Lymphoma |
| ❑ | Ménière's Disease |
| ❑ | Obstructive Sleep Apnea |
| ❑ | Peripheral Vascular Disease |
| ❑ | Pneumonia |
| ❑ | Pulmonary Embolism |
| ❑ | Renal Failure |
| ❑ | Rheumatoid Arthritis |
| ❑ | Sarcoidosis |
| ❑ | Seizure Disorder |
| ❑ | Sjögren's Syndrome |
| ❑ | Stroke |
| ❑ | Trigeminal Neuralgia |
| ❑ | Tuberculosis |
| ❑ | Vasculitis |
| ❑ | Vertigo |
| ❑ | Von Willebrand's Disease |

## Please check all that apply

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