PATIENT INFORMATION:

Name _____ Date of Birth _____

Address _____ Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

_____ Phone_____☐Cell ☐Work ☐Home

City_____ Zip_____ Phone_____☐Cell ☐Work ☐Home

Email Address _____

Patient's Sex: ☐☐ Male ☐☐ Female ☐ Other

Patient's Social Security #_____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Other ☐ Declined to State

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to State

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy: _____ Location of Pharmacy: _____

RESPONSIBLE PARTY: ☐ CHECK IF PATIENT IS 18 OR OLDER, IF NOT PLEASE COMPLETE THIS SECTION

Name _____ Address _____

Phone _____☐Cell ☐Work ☐Home _____

Phone _____☐Cell ☐Work ☐Home City_____ Zip_____

Social Security #_____ Relationship to Patient_____

Date of Birth ___ _____ Sex: ☐ Male ☐ Female ☐ Other

EMERGENCY CONTACT: ☐ CHECK IF SAME AS RESPONSIBLE PARTY

Name _____ Address _____

Phone _____☐Cell ☐Work ☐Home _____

Phone _____☐Cell ☐Work ☐Home City_____ Zip_____

Social Security #_____ Relationship to Patient_____

Date of Birth _____ Sex: ☐ Male ☐☐ Female ☐ Other

PRIMARY INSURANCE: SECONDARY INSURANCE:

IF YOU DID NOT GIVE THE FRONT DESK YOUR INSURANCE CARDS, PLEASE COMPLETE THIS SECTION.

Insurance Carrier _____ Insurance Carrier _____

Insured ID # _____ Insured ID # _____ Policy

Group # _____ Policy Group # _____ Policy Holder

_____ Policy Holder _____

Policy Holder SS#_____ Policy Holder SS#_____

Patient Name: _____ **Date of Birth:** _____

FINANCIAL AGREEMENT

I understand my insurance is a contract between myself and my insurance company and it is my responsibility to determine if providers are in network with my insurance. Texas ENT & Allergy will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments and coinsurances at the time of service. If a referral and/or preauthorization is required by my insurance company, I will assist Texas ENT & Allergy in obtaining the referral and/or preauthorization. Texas ENT & Allergy may verify my benefits; however the final determination will be made by my insurance company at the time of payment. I understand that I am ultimately responsible for any balance on my account.

COLLECTION FEES AND RETURNED CHECKS

I agree to reimburse Texas ENT & Allergy any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt and all costs, and expenses, including reasonable attorneys' fees incurred in collection efforts. I understand a $30.00 service charge will be charged for all returned checks.

ASSIGNMENT OF BENEFITS

I hereby assign to Texas ENT & Allergy such insurance benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION

I hereby allow Texas ENT & Allergy to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

CONSENT FOR TREATMENT

I hereby authorize Texas ENT & Allergy to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary. I authorize Texas ENT & Allergy to access my online prescription information.

DISCLOSURE

If it is recommended that you receive medical treatment from The Physicians Centre or Park Hudson Surgical Center, it is our obligation to inform you that Andrew L. de Jong, M.D. has a minority ownership in The Physicians Centre and Park Hudson Surgical Center and Kellous A. Price, M.D. has a minority ownership in Park Hudson Surgical Center. Texas ENT & Allergy also offers in-office CT and ultrasound imaging. You should be aware that alternative health care facilities are available to you. Referral to alternative facilities will be provided at your request.

PRIVACY PRACTICES

Texas ENT & Allergy is required by law to maintain the privacy of a patient's protected health information. In addition we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information below. Video or audio recording is strictly prohibited.

I am 18 years or older and authorize release of this information to my parents

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, Consent for Treatment and Disclosure as listed above. My signature below indicates that I have reviewed a copy of the Texas ENT & Allergy Notice of Privacy Practices and I have indicated any restrictions on my protected health information below. Scanned signatures suffice as originals.

Patient or responsible party signature **Date**

Person signing on behalf of patient (print name) **Relation to patient**

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PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to complete this form in its entirety.

Patient Full Name _____ Date of Birth _____ Appt Date _____

What is the main reason we are seeing you today?

_____

Have you had any recent tests for this problem? (CT Scan, MRI, Blood Work, etc):

_____

CURRENT MEDICATIONS:

Please provide a list of medications that you are currently taking (including prescription, over-the-counter or supplements (please use the back of this page if you need more space):

Medication name	Dosage	How often taken

MEDICATION ALLERGIES:

Check here if you have no known medication allergies ☐

Medication name	Reaction

NON-MEDICATION ALLERGIES (Animals, insects, perfumes, latex, dust, etc):

Stimuli	Reaction

PAST MEDICAL HISTORY:

Place a check box next to any condition that you have previously been diagnosed with:

- ☐ Breast cancer
- ☐ Lung cancer
- ☐ Skin cancer
- ☐ Larynx cancer
- ☐ Esophageal cancer
- ☐ Thyroid cancer
- ☐ Migraine headaches
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Allergic rhinitis
- ☐ Sleep apnea
- ☐ Deep venous thrombosis
- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Renal failure
- ☐ Stroke
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Anemia
- ☐ Hemophilia
- ☐ HIV

List any other medical conditions that you have been diagnosed with that are not listed above:

_____

PAST SURGICAL HISTORY:

Please list any past surgeries you have had:

Date	Type of surgery

PAST HOSPITAL ADMISSIONS:

Please list any previous hospital admissions you have had:

Date	Reason for hospital admission

FAMILY HISTORY:

Place a check in any row where a relative had the listed medical problem:

	Father	Mother	Children	Maternal grandfather	Maternal grandmother	Paternal grandfather	Paternal grandmother
Anesthesia complications							
Bleeding problems							
Diabetes							
Hearing loss							
Allergies							
Asthma							
Heart disease							

Thyroid cancer							
Cancer							

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No How often do you drink alcohol: _____ Do you smoke cigarettes? ☐ Yes ☐ No How many cigarettes do you smoke per day: _____ If you do not currently smoke, have you in the past? ☐ Yes ☐ No When did you quit? _____ Do you chew tobacco? ☐ Yes ☐ No

REVIEW OF SYSTEMS:

Place a check box next to any symptoms you are currently having:

- ☐ Fatigue
- ☐ Fever
- ☐ Sleep disturbance
- ☐ Weight loss
- ☐ Blurry vision
- ☐ Itchy/red eyes
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Thyroid problems
- ☐ Cough
- ☐ Wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Muscle aches
- ☐ Painful joints
- ☐ Eczema
- ☐ Hives
- ☐ Keloid formation
- ☐ Change in sense of smell
- ☐ Change in sense of taste
- ☐ Headaches
- ☐ Fainting
- ☐ Anxiety
- ☐ Depressed mood
- ☐ Psychiatric condition

PLEASE RETURN COMPLETED PAPERWORK TO THE FRONT DESK.

THANK YOU.