

EAR, NOSE & THROAT CENTER OF AUSTIN

Patient Information

(Please Print)

Today's Date ____/____/____

Name _____
Last First M.I.

Address _____
Street Apt # City State Zip

Home Phone (____) _____ Cell Phone (____) _____

SS# _____ Date of Birth ____/____/____ Age _____ Sex _____

In case of an Emergency, who should be notified? _____ Phone (____) _____

Do we have permission to:

Y / N Leave a message on your answering machine at HOME?

Y / N Leave a message at work?

Y / N Discuss your medical condition with any member of your household?

If so, with whom _____ Relationship _____

Referring Physician _____

PCP _____

Guarantor (Responsible party-if different from patient)

Name _____
Last First M.I.

Address _____
Street Apt # City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Ext. _____ Sex _____

SS# _____ Date of Birth ____/____/____ Age _____ Relationship to Patient: _____

Primary Insurance Information

Primary Insurance Name _____ Employer (Group) _____

Policy Holder _____ DOB ____/____/____ SS# _____
Last First M.I.

Effective Date ____/____/____

Secondary Insurance Information

Secondary Insurance Name _____ Employer (Group) _____

Policy Holder _____ DOB ____/____/____ SS# _____
Last First M.I.

Effective Date ____/____/____

PLEASE CONTINUE ON REVERSE

RELEASE OF INFORMATION

I authorize Ear, Nose & Throat Center of Austin to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical and Surgical care.

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Ear, Nose & Throat Center of Austin otherwise payable to me. I further certify I have provided Ear, Nose & Throat Center of Austin a complete list of the insurance companies with which I have Medical and/or Surgical coverage.

CONSENT TO TREATMENT

I authorize Ear, Nose & Throat Center of Austin and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order related services on my behalf.

FINANCIAL AGREEMENT

Unless other arrangements have been made in advance by either you or your health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal check, Visa, MasterCard, Discover, and American Express. There will be a \$25 fee on any returned checks.

We have made prior arrangements with many health plans to accept an assignment of benefits. We will submit a claim to those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. After the claim has been considered, we will bill you for any balance not previously paid. If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send a claim for you on an unassigned basis. This means our charges for your care and treatment are due at the time of service and your insurer will send their reimbursement directly to you.

Your insurance policy is a contract between you and your insurance company; the doctor is not involved. If you have questions or concerns regarding your plans coverage on procedures, services considered screenings, medications or particular conditions, you are responsible for obtaining this information prior to your appointment. You agree to pay in full for all services considered "non-covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay in consideration of the services provided, or you do not have insurance, you agree to pay all charges of Ear, Nose & Throat Center of Austin. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection, including interest applied by a collection agency and attorney fees. Any suit filed may be brought in the county where the services are rendered.

Please Initial Below

_____ Specific to the field of Otolaryngology, your physician may need to perform certain procedures for proper diagnoses of your condition. This may include, but is not limited to, fiberoptic examination of the voicebox, throat or sinuses. Most insurance carriers consider these exams to be surgical procedures and therefore are subject to surgical deductibles and copay as they apply. Payment for these procedures are due at the time of service.

I agree that all of the information provided is current and correct to the best of my knowledge. I agree to notify Ear, Nose, & Throat Center of Austin of any changes to the information provided in this form as soon as possible.

Patient Name (please print) _____

Signature of Guarantor _____ **Date** _____

Ear Nose and Throat Center of Austin

ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Full Name _____ Male Female Date of Birth _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Address _____

(Current Medications)

Are you taking ANY kind of medication now? No Yes If yes, please list below *include dosages.*
 (This includes prescription, over-the-counter medicines including nasal sprays, or herbal medications)

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list

Name of Medication	Type of Reaction

(Non-Medication Allergies) Are you allergic to Please Circle if allergic to: Eggs, Peanuts, Seafood, other _____

Iodine No Yes Latex No Yes, Tape No Yes, Contrast Dye? No Yes
 Have you ever had an allergy test? No Yes

(Past Health History) Have you ever been *DIAGNOSED* with any of the following problems?

- | | |
|--|--|
| <p>Cancer (bone cancer, lung cancer, unknown type of skin cancer, thyroid cancer) other _____ <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Ears:</p> <p>Hearing Loss <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Cerumen Impaction <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Nose and Sinus:</p> <p>Nasal Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Heart and Blood Vessels:</p> <p>High / Elevated Cholesterol <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>High Blood pressure <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Lungs and Respiratory:</p> <p>Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Stomach and Digestive:</p> <p>Duodenal ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Stomach ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Genitourinary:</p> | <p>Renal failure <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Mental & Emotional:</p> <p>Anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Depression <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Glands, Hormones, and Sugar Control:</p> <p>Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Thyroid deficiency <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Thyroid excess <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Blood & Lymph Node problems:</p> <p>Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Allergies, Immune & Infectious Problems:</p> <p>HIV <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Infectious mononucleosis <input type="checkbox"/> No <input type="checkbox"/> Yes</p> |
|--|--|

(Surgeries and Hospitalizations)

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes

If yes, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery? No Yes

If yes, list any surgeries and when they were done. _____

Have you been hospitalized for a medical problem before? No Yes

If yes, list hospitalizations, the reason for admission and the date. _____

(Family History)

Specific Anesthesia Problem Mother Father Brother Sister
Cancer:
Lung Cancer Mother Father Brother Sister
Ears:
Hearing Loss before age 20 Mother Father Brother Sister
Hearing Loss after age 20 Mother Father Brother Sister
Nose and Sinus:
Nasal Allergies Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister
Hypertension Mother Father Brother Sister
Lungs and Respiratory:
Asthma Mother Father Brother Sister
Brain and Nervous:
Stroke Mother Father Brother Sister
Blood & Lymph Node problems:
Bleeding/clotting problem Mother Father Brother Sister
Other _____ Mother Father Brother Sister

(Social History)

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you use drugs recreationally? No Yes If yes, please list _____

Are you exposed to second hand smoke? No Yes

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How often

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had

Constitutional Symptoms No Yes

(Fever, sleeping problems, unintentional weight loss)

Eye problems No Yes

(Double vision, itchy eyes)

Ears, Nose, Mouth and Throat problems No Yes

(Dizziness, ear drainage, hearing loss, ear pain,
Ringing, chronic congestion, post-nasal drainage,
Hoarseness/change in voice, snoring, sore throat,
Ulcers)

Cardiovascular No Yes

(Blacking out or fainting,
Bluish discoloration of lips or fingernails, chest pain,
irregular heartbeat, leg cramps, swelling of ankles)

Respiratory problems No Yes

(freq non-productive cough, freq productive cough,
Shortness of breath, wheezing)

Gastrointestinal problems No Yes

(abdominal pain, diarrhea, heartburn, nausea,
vomiting)

Musculoskeletal problems No Yes

(Neck pain)

Neurological problems No Yes

(Headache, numbness, severe face pain, seizures,
weakness)

Problems with Endocrine No Yes

(Appetite increased, increased fatigue,
Feel hot when others do not, feel cold all the time,
Neck has enlarged, unwanted weight change)

Problems with Hematological/Lymphatic No Yes

(Bleeds excessively after injury, bruises easily,
Neck masses or lumps)

Allergic, Infectious, Immunologic Problems No Yes

(Food intolerances, hives,
Severe reaction to insect bites, frequent sneezing)

What is the main reason you are seeing the doctor today?