TEXAS EAR, NOSE & THROAT SPECIALISTS, L.L.P.

NEW PATIENT INFORMATION

Date: ______________________

GENERAL PATIENT INFORMATION (Please Print)

Patient Name: ______________________ Date of Birth: ______________
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other
Street Address: ______________________ Home Phone: ______________
City/State: ______________ Zip: ________ Cell Phone #: ______________
Patient's Employer: ______________________ Email Address: ______________
Employer's Address: ______________________ Guarantor SS#: ______________
Business Phone: ______________ Occupation: ______________
Emergency Contact Name: ______________________ Phone #: ______________
Spouse's Name: ______________ Business Phone: __________ Cell #: ______________
Full Time Student? ______Yes ______No If yes, Name of School: ______________
If patient is a minor: Father: ______________ Home #: ________ Work #: ________ Cell #: ________
Mother: ______________ Home #: ________ Work #: ________ Cell #: ________
Referred by: ______________________

RESPONSIBLE PARTY INFORMATION (Complete Only If Other Than Patient)

Responsible Party: ______________ Home Phone: ______________ Cell #: ______________
Relationship to Patient: ______________ Driver's License #: ______________ Date of Birth: ______________
Street Address: ______________ City/State: ______________ Zip: ________
Employer: ______________________ Occupation: ______________
Employer's Address: ______________________ Business Phone: ______________

INSURANCE INFORMATION (Please Allow Us To Make A Copy Of Your Insurance Card(s) and Driver's License)

Primary Insurance: Please check one: ☐ Medicare ☐ PPO ☐ HMO
Insurance Company: ______________ ID#: ______________ Group#: ______________
Insurance Company Phone Number: ______________________
Policyholder Name: ______________ Relationship to Patient: ______________ Date of Birth: ______________
Home Phone: ______________ Cell Phone: ______________ Business Phone: ______________
Employer & Address: ______________________ Occupation: ______________

Is there another health insurance benefit plan? ________Yes ________ No
If yes, please complete information below:

Secondary Insurance: Please check one: ☐ Medicare ☐ PPO ☐ HMO
Insurance Company: ______________ ID#: ______________ Group #: ______________
Insurance Company Phone Number: ______________________
Policyholder Name: ______________ Relationship to Patient: ______________ Date of Birth: ______________
Home Phone: ______________ Cell Phone: ______________ Business Phone: ______________
Employer & Address: ______________________ Occupation: ______________

If no, please sign statement below:
I acknowledge that I do not have a secondary health insurance plan.

______________________ ______________________
(Patient Signature) (Guarantor Signature)

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for payment of all copays, co-insurance amounts, deductibles, and/or noncovered services that are not paid by my insurance company.

______________________ ______________________
(Patient/Guarantor Signature) (Date)

MEDICAL HISTORY

Date: ___________________________

Name: _______________________________________ Ht: _________________ Wt: ______________lbs

Please state specific reason for your visit: ____

Who is your primary care doctor? _____________________________ Who referred you here? ____________________

Do you have a history of (please circle all applicable):

High blood pressure	Anemia	Seizures	Shortness of breath
Thyroid problems	Migraines	Wheezing	Bladder infection
Stroke	Abnormal heart rhythm	Jaundice	Nonmigraine headache
Fever	Diarrhea	Back pain	Heart problems
Constipation	Arthritis	Hepatitis	
Immune deficiency	Asthma/COPD	Radiation therapy	
Diabetes	Cancer	Weight loss	

Other syndrome or major medical diagnosis: ____

Do you smoke cigarettes/pipes/cigars: _______ How many per day?______________ For how long? ______________

Do you dip or chew tobacco? _______________ For how long? _____________________________

If you quit either cigs, dip, chew, pipes or cigars, when? _________________________

Do you drink alcohol? ______________________ How many drinks per day/week/month? _________________________

Have you ever had a reaction to anesthetics? ______________________ If so, what? _____________________________

Do you have a history of increased or easy bleeding?_________________________________

Do you have a history of bad scarring? ___________________________ If so, where? ____________________________

Family history (brothers, sisters, parents, grandparents and children only):

			Relationship
Heart disease	Yes	No	____________________________
Cancer	Yes	No	____________________________
Diabetes	Yes	No	____________________________
Seizure disorder	Yes	No	____________________________
Bleeding disorder	Yes	No	____________________________

Texas
Ear, Nose & Throat
Specialists, L.L.P.

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Texas Ear, Nose and Throat Specialists, L.L.P. unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Texas Ear, Nose and Throat Specialists, L.L.P. infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of the Texas Ear, Nose and Throat Specialists, L.L.P. if any of these situations occur during your treatment period.

______________________________ ____________________
Patient's Printed Name Date of Birth

______________________________ ____________________
Patient/Legal Representative Signature Date

____
Relationship to Patient

______________________________ ____________________
Witness, if signature is marked with an X. Date

TEXAS
EAR, NOSE & THROAT
SPECIALISTS, L.L.P.

Notice of Privacy Practices Acknowledgement

The Notice of Texas Ear, Nose & Throat Specialists, LLP (TENT) Privacy Practices has been made available for my review. This notice provides a description of the uses and disclosures of certain health information. A copy will be provided upon my request.

I understand TENT reserves the right to change its Notice of Privacy Practices and will provide an updated copy posted in the waiting room and/or on its website (www. texasent.net). I may request a copy of the updated Notice of Privacy Practices in person or by phone.

Patient's Printed Name	Date of Birth
Patient/Legal Representative Signature	Date
Relationship to Patient	
Witness, if signature is marked with an X.	Date

The above named patient refused to sign the acknowledgement of review of Notice of Privacy Practices for Texas Ear, Nose and Throat L.L.P.

Practice Representative	Date
Practice Representative	Date

Texas Ear, Nose and Throat Specialists, L.L.P.

Authorization to Release Protected Health Information

I, ______________________________________, hereby authorize the health records of ____,
Patient and/or Guardian **Patient's Name**

to be disclosed or released to the following person and/or persons by any of the following means: **mail, fax and/or orally.**

____
Name **Address** **Relationship**

____
Name **Address** **Relationship**

I authorize Texas Ear Nose & Throat to disclose my PHI in the following manner. I understand that it is my responsibility to notify the practice of any change in this manner of communications and that any disclosure made to the designated address or number, indicated by me, is subject to the disclosure statement within this authorization.

(CHECK THE BOX THAT APPLIES)

- ☐ **Home Telephone:** ___________________________
- ☐ **Work Telephone:**_____________________________
- ☐ **Cell Number:**_______________________________
- ☐ **U.S. Mail:** __________________________________
- ☐ **Fax Number:**_______________________________
- ☐ **E-Mail:** ____________________________________
- ☐ **Leave detailed messages on my answering machine/voicemail**
- ☐ **Leave messages with only call back number (includes staff member name and doctor's office) on my answering machine/voicemail**

My authorization extends to any and all records, unless otherwise marked below.

☐ Progress Notes ☐ Statements of charges or payments ☐ Discharge Summary
☐ Records of all visits ☐ Consultation Reports ☐ History and Physical Examination
☐ Photographs, digital, or images
☐ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
☐ Other (must be specific): ____

I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS, psychiatric illness, alcohol or chemical abuse and dependency will not be released, unless I have given my specific consent to release this information below.

I consent to the release of any positive or negative test result for HIV/AIDS, antibodies for AIDS, or infection with any other causative agent of AIDS or psychiatric illness, alcohol or chemical abuse and dependency with the rest of my medical records.

Patient Signature: **Date:**

________________________ ____________ ____________________
Patient's Printed Name **Date of Birth** **Witness (only if marked with an X)**

________________________ ____________ ____________________
Patient or Guardian's Signature **Signature Date** **Relationship to Patient**

This authorization is valid unless otherwise noted or revoked.

____
Expiration Date

Texas Ear, Nose & Throat Specialists, L.L.P.

Dear Patient:

It is the responsibility of the patient to read their coverage documents for information regarding benefits, limitations, and exclusions. It is also your responsibility to be aware of your co-payments, deductibles, and co-insurance amounts. In an effort to help educate our patients regarding copays, deductibles and coinsurance please note that most managed care insurance companies consider your office visit applicable to your copay which is a separate charge from the procedures or tests listed below. We will be happy to provide you with our office visit fees per your request.

Your insurance could or may apply a test or procedure to your deductible or consider it as a non-covered service. If your physician needs to order a test or procedure and you would like verification of benefits for it (prior to it being performed), **upon your request**, we will be happy to verify that particular benefit.

Listed below are the most common tests and procedures that are performed in our office and the cost associated. Please note this is not an all-inclusive list, and prices are subject to change.

Procedure		TENT Fee
30200	Turbinate Injection	$210.00
30300	Removal of foreign body nose	$425.00
31231	Nasal endoscopy, unilateral or bilateral	$380.00
31237	Nasal endoscopy debridement	$575.00
31575	Laryngoscopy, flexible fiberoptic	$242.00
69200	Removal of foreign body ear	$225.00
69210	Removal impacted cerumen (**Wax removal**)	$105.00
69220	Debridement of mastoid cavity	$250.00
69433	Myringotomy with tube	$370.00
92557	Audiometry (**Hearing Test**)	$100.00
92567	Tympanometry	$ 50.00
95992	Canalith Repositioning	$ 60.00

Many managed care plans may cover these procedures or tests but apply them toward a deductible and/or co-insurance instead of your office visit co-pay. Some plans may consider any of these procedures as a non-covered service. If your plan applies a test or a procedure toward your deductible, co-insurance or considers it as a non-covered service, you will be responsible for payment.

I understand that the benefits quoted to the provider are not a guarantee of payment by my insurance company. I understand and agree that I am responsible for any charges related to the above procedures and/or tests that are performed and are not reimbursed by my insurance company.

If you have any questions, please request to speak with a member of our business office.

__________________________________ ________________

Patient or Legal Guardian Signature   Date

POS® Reorder # 0718885

TEXAS EAR, NOSE & THROAT SPECIALIST, L.L.P.
ALLERGIC REACTIONS TO MEDICATIONS, CURRENT MEDICATIONS
RECENT SURGERIES AND/OR HOSPITALIZATIONS RECORD

NAME: ______________________ Date Of Birth: ______________________

Pharmacy: ______________________ Pharmacy Phone Number: ______________________

Pharmacy: ______________________ Pharmacy Phone Number: ______________________

ALLERGIC REACTION TO MEDICATIONS AND/OR MEDICAL SUPPLIES (ie. Latex, tapes, adhesives, bandaids, iodine)

Allergic to: ______________________ Reaction: ______________________

Allergic to: ______________________ Reaction: ______________________

Allergic to: ______________________ Reaction: ______________________

Allergic to: ______________________ Reaction: ______________________

LIST ALL CURRENT MEDICATIONS: prescription, over-the-counter, vitamins, herbals, "as needed" medications.

				OFFICE USE ONLY			
Medication Name	**Dose**	**How Often**	**Doctor who ordered and reason you are taking medication.**	**Date**	**Date**	**Date**	**Date**

List all Surgeries or Hospitalizations

Date	Surgeries/Hospitalizations	Facility (if applicable)	Initials

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