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

Patient Information Update

Date: _____

GENERAL PATIENT INFORMATION (Please Print in Black Ink)

Patient Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City/State: _____ Zip: _____ Cell Phone #: _____

Email Address: _____

Emergency Contact Name: _____ Phone: _____

If patient is a minor:

Father: _____ Home #: _____ Work #: _____ Cell #: _____

Mother: _____ Home #: _____ Work #: _____ Cell #: _____

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: _____

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: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Race: (Please Circle)
American Indian or Alaska Native / Asian / Native Hawaiian or Other Pacific Islander / Black or African American / White / Hispanic / Other / Other Pacific Islander / Prefer not to answer

Ethnicity: (Please circle) Hispanic or Latino / Non-Hispanic or Latino / Prefer not to answer

Preferred language is English unless otherwise noted here: _____

Would you like to be web enabled for the patient portal: ☐ Yes ☐ No

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I authorize Texas Ear, Nose & Throat Specialists, L.L.P. (TENT), to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services or utilization management review. I authorize the payment of medical benefits to TENT. I understand that I am ultimately responsible for all services whether covered by insurance or not.

_____ _____

(Patient Signature) (Date)

MEDICAL HISTORY

Date: _____

Name: _____ DOB:_____ 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 SPECIALIST, L.L.P.
ALLERGIC REACTIONS TO MEDICATIONS, CURRENT MEDICATIONS
RECENT SURGERIES AND/OR HOSPITALIZATIONS RECORD

Date: _____

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**