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)

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

Texas Ear, Nose, & Throat Specialists, LLP

Patient Authorization

Please read, initial, and sign below.

(Initial)__________**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the Texas Ear, Nose, & Throat Specialists, LLP Financial Policy. I understand I can access the policy online as well at www.texasent.net.

(Initial)__________**Assignment of Benefits**: I hereby authorize payment directly to Texas Ear, Nose, & Throat Specialists, LLP, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Texas Ear, Nose, & Throat Specialists, LLP, information regarding my insurance coverage, including, but not limited to verification of my examination, treatment and/or surgical procedures to my insurance company and/or other third-party payor. I understand that I am financially responsible for payment of copays, co-insurance amounts, deductibles, and/or non-covered services that are not paid by my insurance. I have also reviewed the list of most common procedures and the associated fees (which is subject to change.)

(Initial) ________**Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the Texas Ear, Nose, & Throat Specialists, LLP Notice of Privacy Practices. I understand I can access the Privacy Policy online at www.texasent.net or request a copy from the office.

(Initial) _______**Consent to Treat:** 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.

(Initial) _______**E-Prescribing:** I voluntarily authorize Texas Ear, Nose, & Throat Specialists, LLP to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as I am a patient at this office.

(Initial) ________**Patient Communications:** I understand that Texas Ear, Nose & Throat Specialists, LLP may contact me via email, phone call or text regarding appointment reminders, office updates and satisfaction surveys. I understand I need to notify the practice in writing if I wish to update my preferences.

(Initial)__________I understand I can withdraw my consent at any time by contacting Texas Ear, Nose, & Throat Specialists, LLP in writing 1615 Hospital Parkway, Suite 210, Bedford, TX 76022. Withdrawal may result in dismissal from the practice.

Printed Patient Name:____ **DOB:** _________________________

Patient Signature: ____ **Date:** ________________________

Guardian/Legal Representative Name: __________________________________

Guardian/Legal Representative Signature: _______________________________

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

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