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:** _____

Parent/Guardian Name: _____

Parent/Guardian 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/Guardian 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 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**

PEDIATRIC HEALTH HISTORY

Patient's Name: _____

Age: _____ Birth Date: _____ Height: _____ Weight: _____

Who is your primary care doctor? _____ Who referred you here: _____

What symptoms led to this visit?: _____

Any **Drug Allergies**?: No: _____ Yes: _____

Patients 13 years of age or older

Do you or did you smoke cigarettes/pipes/cigars? _____ How many per day? _____

For how long? _____ years

Do you dip or chew? (circle one). How many years? _____

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

Does the child have, or has the child ever had one of the following (please check if yes):

___ heart trouble	___ pneumonia	___ blood disorder	___ born premature (before 37 wks.)
___ bronchitis	___ rheumatic fever	___ allergies	
___ asthma	___ anemia	___ seizure	___ hepatitis/jaundice
___ shortness of breath	___ thyroid problems	___ prolonged bleeding	___ urinary problems

List any relevant family history _____

Any syndromes or major medical diagnoses? (please list) _____

Are the child's immunizations up to date? ☐ Yes ☐ No

Does anyone smoke @ home, in a car or where the child spends time? ☐ Yes ☐ No

If not school age, does the child attend daycare or pre-school? Yes ☐ No

Number of episodes your child has had **in the last 12 months:**

___ Strep throats/Tonsillitis ___ Ear infection ___ Sinusitis

Which Antibiotics has your child taken for the above (please check if applicable):

___ Amoxicillin	___ Augmentin	___ Bactrim/Septra	___ Biaxin
___ Ceclor	___ Ceftin	___ Cefzil	___ Clindamycin/Cleocin
___ Emycin	___ Omnicef	___ Rocephin shot	___ Septra
___ Suprax	___ Vantin	___ Zithromax	___ Cedax

Does your child snore at night? ___Yes ___ No

Is your child a mouth breather? ___Yes ___ No

Today's Date: _____ Parent's Signature: _____

M F B G