

PATIENT INFORMATION:

Name _____

Date of Birth _____

Address _____

Marital Status: Married Single Divorced Widowed

Phone _____ Cell Work Home

City _____ Zip _____

Phone _____ Cell Work Home

Email Address _____

Patient's Sex: Male Female

Patient's Social Security # _____

Race: White Black Hispanic Other Declined to State

Preferred Language: English Spanish

RESPONSIBLE PARTY: CHECK IF PATIENT IS 18 OR OLDER, IF NOT PLEASE COMPLETE THIS SECTION

Name _____

Address _____

Phone _____ Cell Work Home

Phone _____ Cell Work Home

City _____ Zip _____

Social Security # _____

Relationship to Patient _____

Date of Birth _____

Sex: Male Female

PRIMARY INSURANCE: **SECONDARY INSURANCE:**
IF YOU DID NOT GIVE THE FRONT DESK YOUR INSURANCE CARDS, PLEASE COMPLETE THIS SECTION.

Insurance Carrier _____

Insurance Carrier _____

Insured ID # _____

Insured ID # _____

Policy Group # _____

Policy Group # _____

Policy Holder _____

Policy Holder _____

Policy Holder SS# _____

Policy Holder SS# _____

Relationship to Patient _____

Relationship to Patient _____

Policy Holder Date of Birth _____

Policy Holder Date of Birth _____

Policy Holder Employer _____

Policy Holder Employer _____

PROVIDER INFORMATION:

Referred By: _____ Primary Care Physician? _____

Patient/Friend Insurance Newspaper Ad Yellow Page Ad Website

PATIENT HEALTH HISTORY

ENTERED BY: _____

In order for us to obtain a complete medical history, it is important for you to complete this form in its entirety.

Patient Full Name _____ Date of Birth _____ Appt Date _____

Pharmacy Preference (include location) _____ Laboratory Preference _____

Referred By _____ Name of Primary Care (Family) Physician _____

What is the main reason we are seeing you today?

Have you had any recent tests for this problem? (CT Scan, MRI, Blood Work, etc) _____

CURRENT MEDICATIONS:

Are you taking ANY medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes **If yes, please list below.**

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes **If yes, please list below.**

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Check any of the following that you are allergic to:

- Animal Exposure Dust Moldy Places Pollen Iodine
 Perfume Latex Ant Stings Bee Stings Fly/Flying Insects
 Other: _____

Have you ever had an allergy skin test? No Yes Month and Year _____

Have you ever had an allergy blood test? No Yes Month and Year _____

PAST HEALTH HISTORY: Place a check in the box next to any condition for which you have been previously diagnosed.

Cancer:

- Breast Cancer Yes What year? _____
Lung Cancer Yes What year? _____
Prostate Cancer Yes What year? _____
Skin Cancer Yes What year? _____
Throat Cancer Yes What year? _____
Other Cancer Yes What type/year? _____

Eyes:

- Cataracts Yes What year? _____
Glaucoma Yes What year? _____

Nose and Sinus:

- Nasal Allergies Yes What year? _____

Mouth and Throat:

- Sleep Apnea Yes What year? _____

Head & Face:

- Migraine Headache Yes What year? _____

Heart and Blood Vessels:

- Deep Vein Thrombosis Yes What year? _____
- High/Elevated Cholesterol Yes What year? _____
- High Blood pressure Yes What year? _____
- Heart Attack Yes What year? _____

Lungs and Respiratory:

- Asthma Yes What year? _____
- Chronic Bronchitis Yes What year? _____
- Emphysema Yes What year? _____
- Hemophilia Yes What year? _____
- Tuberculosis Yes What year? _____

Stomach and Digestive:

- Gastroesophageal Reflux Yes What year? _____
- Hepatitis Yes What year? _____
- Stomach ulcer Yes What year? _____

Kidney and Gender Problems:

- Renal failure Yes What year? _____
- Enlarged Prostate Yes What year? _____

Are you pregnant now? Yes Due Date? _____
 No

Brain:

Stroke Yes What year? _____

Mental & Emotional:

Depression Yes What year? _____
 Chronic Anxiety Yes What year? _____

Glands, Hormones, and Sugar Control:

Diabetes Yes What year? _____
 Thyroid dysfunction Yes What year? _____

Blood & Lymph Node problems:

Anemia Yes What year? _____

Allergies, Immune & Infectious Problems:

HIV Yes What year? _____
 Infectious mononucleosis Yes What year? _____

Other Medical

Issues: _____

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 ever had any other type of surgery? No Yes

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

Have you been hospitalized for any other medical problem before? No Yes

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

SERIOUS INJURIES:

Have you had any Head, Facial, or Ear injuries: No Yes If yes, when: _____ What Type: _____

TESTS AND IMMUNIZATIONS:

Are your immunizations up to date? No Yes

Have you taken the Influenza Vaccine (flu shot) No Yes Month and Year _____

Have you taken the Pneumococcal Vaccine (pneumonia shot) No Yes Month and Year _____

Have you had a Colonoscopy? No Yes Month and Year _____

Have you had a Fecal Occult Blood Testing? No Yes Month and Year _____

Have you had a Flexible Sigmoidoscopy? No Yes Month and Year _____

Have you had a Mammogram? No Yes Month and Year _____

FOR CHILDREN (UNDER AGE 13) please complete the following:

Was patient's mother's pregnancy normal? No Yes Not Sure

Did patient pass their newborn screening? No Yes Not Sure

PATIENT'S FAMILY HISTORY: Check the corresponding box if the family member has had any of the following:

Anesthesia Problem	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lung Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Thyroid Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing Loss after age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing Loss before age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nasal Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Bleeding/Clotting Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

PATIENT'S SOCIAL HISTORY:

Patient's Occupation? _____ Check here if patient is retired

Has patient 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)		

Does patient consume alcohol? No Yes
If yes, please complete the following:

Type of Alcohol	How Much	How often

Is patient currently using tobacco? No Yes

Does patient use drugs recreationally? No Yes If yes, please list _____

Describe patient's caffeine usage: none
 about 1 caffeinated drink per day
 about 2 to 3 caffeinated drinks per day
 4 or more caffeinated drinks per day
 other amount: _____

Is patient exposed to second hand smoke? No Yes

Home Living Situation (mark all that apply)

Alone Spouse Children Mother Father In Assisted Living Nursing Home Roommate
 Grandparent Other _____

Does the patient attend day care? (UNDER AGE 13) No Yes

REVIEW OF SYSTEMS: Mark yes or no and CHECK any of the following patient is currently experiencing.

General health problems No Yes fever sleeping problems unintentional weight loss fatigue (excessive)

Behavior problems No Yes poor performance in school daytime sleepiness

Eye problems No Yes painful eye itchy eyes blurred vision loss of vision

Ear problems No Yes ear pain ear drainage hearing loss dizziness ringing

Nose & Sinus problems No Yes nasal congestion frequent nosebleeds post nasal drainage

- Mouth & Throat problems** No Yes - hoarseness or other voice changes partials or dentures
 belching sour material into throat sores in mouth Snoring
- Heart or circulation problems** No Yes - blacking out or fainting chest pain heart murmur
 irregular heartbeat leg cramps swelling of ankles
- Lung or respiratory problems** No Yes - freq non-productive cough freq productive cough shortness of breath
 coughing up blood wheezing
- Stomach problems** No Yes - abdominal pain diarrhea heartburn nausea vomiting
 painful swallowing
- Genitourinary problems** No Yes - bed wetting increased frequency of urination
- Bone, joint, or muscle problems** No Yes - pain in neck painful joints stiffness in joints swelling of joints
- Skin problems** No Yes - poor healing wound skin blisters or lesions
- Brain or Nervous system problems** No Yes - numbness seizures change in sense of smell
 change in sense of taste drooping of one side of face headache
 severe face pain tremor
- Problems with Glands, Hormones** No Yes - feel hot when others do not increased appetite cold feeling
 thirst increased unintentional weight gain
- Problems with Blood or Lymph nodes** No Yes - bleeds excessively after injury bruises easily lumps in neck
- Problems with Allergies** No Yes - food intolerances freq sneezing hives severe reaction to insect bite

**PLEASE RETURN COMPLETED
PAPERWORK TO THE FRONT DESK.**

THANK YOU.

Patient Name: _____

Date of Birth: _____

FINANCIAL AGREEMENT

I understand my insurance is a contract between myself and my insurance company and it is my responsibility to determine if providers are in network with my insurance. Texas ENT & Allergy will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments and coinsurances at the time of service. If a referral and/or preauthorization is required by my insurance company, I will assist Texas ENT & Allergy in obtaining the referral and/or preauthorization. Texas ENT & Allergy may verify my benefits; however the final determination will be made by my insurance company at the time of payment. I understand that I am ultimately responsible for any balance on my account.

COLLECTION FEES AND RETURNED CHECKS

I agree to reimburse Texas ENT & Allergy any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt and all costs, and expenses, including reasonable attorneys' fees incurred in collection efforts. I understand a \$30.00 service charge will be charged for all returned checks.

ASSIGNMENT OF BENEFITS

I hereby assign to Texas ENT & Allergy such insurance benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION

I hereby allow Texas ENT & Allergy to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

CONSENT FOR TREATMENT

I hereby authorize Texas ENT & Allergy to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary.

DISCLOSURE

In the event it is recommended that you receive medical treatment from The Physicians Centre, HMH Clinical Management or Park Hudson Surgical Center, it is our obligation to inform you that Andrew L. de Jong, M.D. has a minority ownership in The Physicians Centre and Park Hudson Surgical Center and Ronald B. Kuppersmith, M.D. has a minority ownership in HMH Clinical Management and Park Hudson Surgical Center. You should be aware that alternative health care facilities are available to you.

PRIVACY PRACTICES

Texas ENT & Allergy is required by law to maintain the privacy of a patient's protected health information. In addition we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information below. Video or audio recording is strictly prohibited.

Check one: **No restrictions (immediate family members may have access to my records)**
 Restrictions (list any individuals that are NOT allowed to have access to records)

I am 18 years or older and authorize release of this information to my parents: **Yes** **No**

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, Consent for Treatment and Disclosure as listed above. My signature below indicates that I have reviewed a copy of the Texas ENT & Allergy Notice of Privacy Practices and I have indicated any restrictions on my protected health information below. *Scanned signatures suffice as originals.*

Patient or responsible party signature

Date

Person signing on behalf of patient (print name)

Relation to patient