PATIENT INFORMATION:

Name_____ Date of Birth _____
Address_____ Social Security #_____
_____ Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed
City, State, Zip_____ Sex: ☐Male ☐Female
Phone _____Type_____ Employment Status: ☐Employed ☐Unemployed ☐Retired
Phone _____Type_____ Employer:_____

Email Address_____

PRIMARY INSURANCE:

Carrier_____
Insured ID#_____
Policy Group_____
Insured Name_____SS#_____
Relationship to patient_____Date of Birth_____
Insured's Employer_____

SECONDARY INSURANCE:

Carrier_____
Insured ID#_____
Policy Group_____
Insured Name_____SS#_____
Relationship to patient_____Date of Birth_____
Insured's Employer_____

RESPONSIBLE PARTY: ☐ CHECK IF SAME AS PATIENT

Name_____ Date of birth _____
Address _____ Social Security #_____
City, State, Zip_____ Employer_____
Phone_____Type_____ Phone _____Type_____

REFERRED BY: ☐Physician:_____ ☐Patient/Friend ☐Insurance ☐Newspaper Ad ☐Yellow Page Ad ☐Website

FINANCIAL AGREEMENT

I understand my insurance is a contract between myself and my insurance company and 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 understand a collection fee will be added to my account balance if placed with a collection agency to cover the cost charged by the collection agency. I agree to pay this fee associated with the collection of any overdue balance. 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.

MUST CHECK ONE: ☐ No restrictions (immediate family members may have access to patient records)
☐ Restrictions (these individuals may NOT have access to patient records)

_____

If it applies: **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 above. *Scanned signatures suffice as originals.*

_____

Patient or Responsible Party Signature Date

_____

Person signing on behalf of patient (print name) Relation to Patient

PATIENT HEALTH HISTORY

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 _____

Race: ☐White ☐Black ☐Hispanic ☐Other ☐Declined to State

Ethnicity: ☐Hispanic ☐Non Hispanic ☐Declined to State Preferred Language: ☐English ☐Spanish

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 ☐ Pollen ☐ Moldy Places ☐ 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?_____

Head & Face:

Migraine Headache ☐ Yes What 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?_____

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?_____

Kidney and Gender Problems:
Stomach ulcer ☐ Yes What year?_____
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 a 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: _____

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 _____

DIAGNOSTIC SCREENING TESTS:

FOR CHILDREN (UNDER AGE 15) please complete the following:

Do they attend day care? ☐ No ☐ Yes
Was patient's mother's pregnancy normal? ☐ No ☐ Yes ☐ Not Sure
Did patient pass their newborn screening? ☐ No ☐ Yes ☐ Not Sure

FOR ADULTS (AGE 50-75) please complete the following:

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 _____

FAMILY HISTORY: **Check the corresponding box if the family member has had any of the following:**

Anesthesia Problem	☐ Mother	☐ Father	☐ Brother	☐ Sister
Lung Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
Thyroid Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
Hearing Loss after age 20	☐ Mother	☐ Father	☐ Brother	☐ Sister
Hearing Loss before age 20	☐ Mother	☐ Father	☐ Brother	☐ Sister
Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister
Asthma	☐ Mother	☐ Father	☐ Brother	☐ Sister
Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister
Bleeding/Clotting Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister
Nasal Allergies	☐ Mother	☐ Father	☐ Brother	☐ Sister

SOCIAL HISTORY:

What is or was your occupation? _____ ☐ **Check here if you are retired**

Have you 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)		

Do you consume alcohol? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Alcohol	How Much	How often

Are you currently using tobacco? ☐ **No** ☐ **Yes**

Are you exposed to second hand smoke? ☐ **No** ☐ **Yes**

Do you use drugs recreationally? ☐ **No** ☐ **Yes** **If yes, please list_____**

Describe your 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: _____**

Home Living Situation (mark all that apply)

☐ **Alone** ☐ **Spouse** ☐ **Children** ☐ **Mother** ☐ **Father** ☐ **In Assisted Living** ☐ **Nursing Home** ☐ **Other**

REVIEW OF SYSTEMS: **Mark yes or no and CHECK any of the following you have recently had.**

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

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 ☐ fever blisters or cold sores ☐ 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

Genitourinary problems ☐**No** ☐ **Yes -** ☐bed wetting ☐urinating more than usual

Stomach problems ☐**No** ☐ **Yes -** ☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting ☐painful swallowing

Bone, joint, or muscle problems ☐ **No** ☐ **Yes -** ☐pain in neck ☐painful joints ☐stiffness in joints ☐swelling of joints

Skin problems ☐ **No** ☐ **Yes -** ☐moles that have changed ☐ 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