PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ (City) _____ (State) _____ (Zip) _____

PATIENT DATA

Home Phone: (_____) _____

Cell Phone: (_____) _____

Social Security #: _____

Birthdate: _____/_____/_____ Age: _____

Sex: _____ Occupation: _____

Employer: _____

Work Phone: (_____) _____

Email: _____

FAMILY DATA

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Phone: (_____) _____

If PATIENT is a MINOR, Complete Below

Father's Name: _____

Father's Employer: _____

Father's Phone: _____

Mother's Name: _____

Mother's Employer: _____

Mother's Phone: _____

EMERGENCY DATA (Friend or Relative NOT living with you)

Name: _____

Phone: _____

Primary Care Physician: (Last) _____, (First) _____

Referred By: _____ Physician? YES/NO

Family Members Previously Seen In This Office: _____

INSURANCE

POLICY HOLDER of PRIMARY Insurance: _____ Relationship to Patient: _____

Social Security # of Policy Holder: _____ Birthdate: _____/_____/_____ Age: _____

POLICY HOLDER of SECONDARY Insurance: _____ Relationship to Patient: _____

Social Security # of Policy Holder: _____ Birthdate: _____/_____/_____ Age: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Home Phone: (_____) _____

Relationship to Patient: _____ Birthdate: _____/_____/_____ Age: _____

Insurance Company: _____

I directly assign all medical/ surgical benefits to Ear, Nose & Throat Specialty Care, PLLC and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. Medicare patie please note that you are signing a one-time authorization, and regulations pertaining to Medicare assignment of benefits apply I understand that this authorization is valid for 1 year following the date listed below.

Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

Patient	DOB
Phone	PCP

Thank you for filling out the information below. It will improve the care we can give you.

PAST MEDICAL HISTORY

Please list any significant medical illnesses you have (such as diabetes, heart disease, stroke, high blood pressure, bleeding problems, depression, etc.)

_____ _____

_____ _____

_____ _____

SURGERIES Please list previous surgeries (for example tonsillectomy, appendectomy, heart bypass, etc.)

_____ _____

_____ _____

_____ _____

MEDICATIONS Please list all medications (including over the counter medicines, such as aspirin, taken regularly)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES TO MEDICATIONS (Please list)

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Do you smoke?

o NO, I have never been a smoker.

o NO, I quit in _____ (year). I previously smoked _____ packs per day for _____ years.

o YES, I have smoked ____ pack(s) per day for _____ years.

FAMILY HISTORY

Do any diseases run in your family?

_____

_____

_____

_____

REVIEW OF SYSTEMS (Please circle symptoms **currently** bothering you. This is *not* intended to be all-inclusive)

General - Fever, weight change, night sweats, feel excessively sleepy during the day

Eye - Itchy eyes, double vision, vision loss

Ear – Hearing loss, pain, drainage, ringing, dizziness

Nose - Sneezing, nosebleeds, stuffy/obstructed nose, drainage, loss of smell

Mouth – Bleeding, ulcers, dental pain, loose teeth, snoring

Neck- Masses, pain

Respiratory – Shortness of breath, cough, wheezing, awake at night with trouble breathing

Cardiovascular -Chest pain, abnormal heartbeats,

GI – Heartburn/reflux, trouble swallowing, stomach ulcer, diarrhea, constipation

Nervous System - Headaches, numbness, hoarseness

Lymphatic - Enlarged lymph nodes, ankle swelling

Mental – Depression, anxiety, memory loss

Skin – Rash, nonhealing sore

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW of the NOTICE OF PRIVACY PRACTICES for *Ear, Nose & Throat Specialty Care, PLLC*

It is Federal law that we ask you to please sign below to acknowledge that you have received and reviewed our *Notice of Privacy Practices* which is provided on a different page of this New Patient Packet prior to any service being provided by us. You are simply consenting to the use and disclosure of your medical information as set forth therein.

Patient Name: _____ Patient Date of Birth: _____

(Please Print Name) (mm/dd/yyyy)

SIGNATURES:

Patient (or Legal Representative): _____ Date: _____

(If Legal Representative, note relationship to Patient): _____

YOU CAN LIST INDIVIDUALS WHO MAY SHARE YOUR HEALTH INFORMATION HERE:
By default, we only discuss private health information either directly with you or with a patient's legal guardian. If there are specific individuals with whom you want to fully share your health information, or if you have unusual or extenuating circumstances that you feel we should know about, you can mention this below:

COMPLAINTS:
If you believe that your privacy rights as described in the Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Ear, Nose & Throat Specialty Care
Attn: HIPAA Officer
411 N. Washington Ave., Suite 6400, Dallas, TX 75246
(214) 826-3681

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.