Central Texas ENT
EAR NOSE THROAT

Patient Information:

Name______________________________

Address______________________________

____

City, State, Zip______________________________

Phone ____________________Type______________

Phone ____________________Type______________

Email address______________________________

Date of birth ______________________________

Social Security #______________________________

Marital Status: ( )Married ( )Single ( )Divorced ( )Widowed

Sex: ( )Male ( )Female

Employment Status:( )Employed ( )Unemployed ( )Retired

Employer:______________________________

Primary Insurance:

Carrier______________________________

Insured ID#______________________________

Policy Group______________________________

Insured Name________________SS#____________

Relationship to patient________Date of birth________

Insured Employer______________________________

Secondary Insurance

Carrier______________________________

Insured ID#______________________________

Policy Group______________________________

Insured Name________________SS#____________

Relationship to patient________Date of birth________

Insured Employer______________________________

Responsible Party

Name______________________________

Address ______________________________

____

City, State, Zip______________________________

Phone__________________________Type________

Phone __________________________Type________

Employer______________________________

Social Security #______________________________

Date of birth ______________________________

Referred by ( ) Physician_______________ ( ) Patient/Friend_________________ ( ) Self Referral

FINANCIAL AGREEMENT

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 as services are rendered. I understand my insurance is a contract between myself and my insurance company and Central Texas ENT will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization is required by my insurance company, I will assist Central Texas ENT in obtaining the referral and/or preauthorization. If payment cannot be made at each visit, I will notify the front-desk staff to make other arrangements. I understand that I am ultimately responsible for any balance on my account.

ASSIGNMENT OF BENEFITS

I herby assign to Central Texas ENT such insurance benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION

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

CONSENT FOR TREATMENT

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

PRIVACY PRACTICES

Central Texas ENT 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.

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, and Consent for Treatment as listed above. My signature below indicates that I have also received a copy of the Central Texas ENT Notice of Privacy Practices and I have indicated any restrictions of my Protected Health Information below. Scanned signatures suffice as originals.

I am 18 years old or older and authorize release of this information to my parents ( )Yes ( )No

Please check one: ( ) No restrictions

( ) Restrictions ______________________________

X

Patient or responsible party signature Date

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

PEDIATRIC ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Appointment Date ______________

Full Name ____ **Male** ☐ **Female** ☐ **Date of Birth** ________________

Pharmacy Preference **(include location)** ____

Referred By _________________________ **Name of Primary Care (Family) Physician** ___________________________

What is the main reason you are seeing the doctor today?

____

CURRENT MEDICATIONS:

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

☐ **No** ☐ **Yes If yes, please list below** ***include dosages***.

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-MEDICATIONALLERGIES:

Are you allergic to anything in the environment such as pollens, dust, food, etc.? ☐ **No** ☐ **Yes**

If **yes**, please indicate what you are allergic to. ____

Have you ever had an allergy test? ☐ **No** ☐ **Yes** If yes, What type - skin or blood ______ When ______ Doctor _____________

PAST HEALTH HISTORY: **Have you ever been *DIAGNOSED* with any of the following problems?**

Cancer (type)____________ ☐ No ☐ **Yes** What year?_________

Nose and Sinus:

Nasal Allergies ☐ **No** ☐ **Yes** What year?_________

Heart and Blood Vessels:

High / Elevated Cholesterol ☐ **No** ☐ **Yes** What year?________

High Blood pressure ☐ **No** ☐ **Yes** What year?________

Lungs and Respiratory:

Tuberculosis ☐ **No** ☐ **Yes** What year?________

Stomach and Digestive:

Duodenal ulcer ☐ **No** ☐ **Yes** What year?________

Hepatitis ☐ **No** ☐ **Yes** What year?________

Stomach ulcer ☐ **No** ☐ **Yes** What year?________

Kidney and Gender Problems:

Renal failure ☐ **No** ☐ **Yes** What year?________

Are you pregnant? ☐ **No** ☐ **Yes**

Mental & Emotional:

Depression ☐ **No** ☐ **Yes** What year?________

Anxiety ☐ **No** ☐ **Yes** What year?________

Glands, Hormones, and Sugar Control:

Diabetes ☐ **No** ☐ **Yes** What year?________

Thyroid deficiency ☐ **No** ☐ **Yes** What year?________

Thyroid excess ☐ **No** ☐ **Yes** What year?________

Blood & Lymph Node problems:

Anemia ☐ **No** ☐ **Yes** What year?________

Allergies, Immune & Infectious Problems:

HIV ☐ **No** ☐ **Yes** What year?________

Infectious mononucleosis ☐ **No** ☐ **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 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:** __________

TEST AND IMMUNIZATIONS:

Immunization status up to date: ☐ **No** ☐ **Yes**

Was patient's mother's pregnancy normal? ☐ **No** ☐ **Yes**

Did patient pass their newborn screening? ☐ **No** ☐ **Yes** ☐ **Not sure**

FAMILY HISTORY:

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister

Ears:

Hearing Loss before age20 ☐Mother ☐Father ☐Brother ☐Sister

Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus:

Nasal Allergies ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:

Heart Disease ☐Mother ☐Father ☐Brother ☐Sister

High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory:

Asthma ☐Mother ☐Father ☐Brother ☐Sister

Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:

Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node problems:

Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister

Other__________ ☐Mother ☐Father ☐Brother ☐Sister

SOCIAL HISTORY:

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 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:** ____________________

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)

Eye problems ☐ **No** ☐ **Yes**
(☐double vision, ☐itchy eyes)

Ear problems ☐ **No** ☐ **Yes**
(☐ear pain, ☐ear drainage, ☐hearing loss, ☐dizziness, ☐ringing)

Nose & Sinus problems ☐ **No** ☐ **Yes**
(☐chronic congestion, ☐ hay fever, ☐sinus drainage ☐face pain)

Mouth & Throat problems ☐ **No** ☐ **Yes**
(☐change in voice, ☐snoring, ☐sore throat, ☐ulcers)

Heart or circulation problems ☐ **No** ☐ **Yes**
(☐blacking out or fainting, ☐bluish discoloration of lips or fingernails, ☐chest pain, ☐irregular heartbeat, ☐leg cramps, ☐swelling of ankles)

Lung or respiratory problems ☐ **No** ☐ **Yes**
☐freq non-productive cough, ☐freq productive cough, ☐shortness of breath, ☐wheezing)

Stomach problems ☐**No** ☐ **Yes**
(☐abdominal pain, ☐diarrhea, ☐heartburn, ☐nausea, ☐vomiting)

Bone, joint, or muscle problems ☐ **No** ☐ **Yes**
(☐pain in neck ☐neck masses or lumps)

Brain or Nervous system problems ☐ **No** ☐ **Yes**
(☐numbness, ☐seizures, ☐severe face pain, ☐weakness)

Problems with Glands, Hormones ☐**No** ☐ **Yes**
(☐feel cold all the time, ☐feel hot when others do not, ☐ increased appetite, ☐increased fatigue, ☐neck has enlarged, ☐unwanted weight change)

Problems with Blood or Lymph nodes ☐ **No** ☐ **Yes**
(☐bleeds excessively after injury, ☐bruises easily ☐swollen glands)

Problems with Allergies ☐ **No** ☐ **Yes**
(☐food intolerances, ☐freq sneezing, ☐hives, ☐post nasal drainage, ☐severe reaction to insect bite)

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NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Central Texas ENT's Privacy Officer at 979-776-8808

OUR PLEDGE REGARDING MEDICAL INFORMATION:
Central Texas ENT, as required by law, Health Insurance Portability and Accountability Act (HIPAA), pledges to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bill, to support the operation of Central Texas ENT, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician whom you have been referred by Central Texas ENT to ensure that the physician has the necessary information to diagnosis and treat you.

Payment
Your protected health information will be used, as needed to obtain payment for your healthcare services. For example, obtaining approval for a surgical procedure may require that your relevant protected health information be disclosed to your insurance company to obtain approval for the procedure.

Healthcare Operations
We may use or disclose, as-needed, your protected health information in order to support the business activities of Central Texas ENT. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging of other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security and Workers' Compensation.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Scanned and faxed signatures will suffice as the original.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to Inspect and Copy You have the right to inspect and receive a copy of medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect or receive a copy of your medical information, you must submit your request in writing to the Health Information Management Department. You may be charged reasonable administrative fees.

Right to Amend If you feel that medical information we have about you is incorrect you may ask to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and submitted to the Health Information Management Department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Central Texas ENT;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made for purposes other than treatment, payment, or healthcare operations or pursuant to your authorization. To request this list or accounting of disclosures, you must submit your request in writing to the Health Information Management Department. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member, friend or other responsible party.

We are not required to agree to your request. *If* we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Health Information Management Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Health Information Management Department. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain the effective date. In addition, each time you register at or are admitted for treatment or healthcare services we will make a copy of the current notice available to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Central Texas ENT or with the Department of Health and Human Services. **You Will Not Be Penalized For Filing A Complaint.** All complaints must be submitted in writing to: Central Texas ENT

Privacy Officer
3201 University Dr E Ste 470
Bryan, TX 77802

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or law will be made only with your written permission. If you provide us permission to use or disclose medical information, you may revoke that permission, in writing, at any time, except to the extent that action has been taken in reliance on your permission. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our original records of the care that we provided to you.