WELCOME TO OUR PRACTICE

New Patient Questionnaire

Adults 18 and older

Today's date: _____ MR#: _____

PATIENT INFORMATION

Last name _____ First Name _____ MI _____ Sex: ❑ M ❑ F

Age _____ Birth Date _____ Social Security # _____ Driver's Lic # _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail address to reach you: _____

May we share your e-mail address with the hospital or surgery center if you schedule surgery with one of our physicians? ❑ Yes ❑ No

Are you employed? Yes _____ No _____ Retired _____ Student _____

If yes, name of Employer _____

Occupation _____

Employer Address _____ Phone _____

Are you married? ❑ Yes ❑ No Name of spouse/partner _____ Phone _____

Spouse/Partner Employer's name & address _____

The Pharmacy you normally use _____ Phone _____

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

Who do you authorize us to speak to regarding your medical care? Please list their name and relationship. _____

_____

PRIMARY INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ PPO ❑ HMO ❑ POS ❑ Private Pay

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

REFERRED BY: ❑ Primary Care Physician ❑ Dentist ❑ Other Physician ❑ Friend ❑ Internet ❑ Other

Have you or any of your family members been seen as patients in this Practice? ❑ Yes ❑ No

If yes, name of patient _____ When? _____

Primary Care Physician _____ Phone _____

Dentist _____ Phone _____

Physician who referred you to our Practice? _____ Phone _____

***Please be sure to include first and last name of your physicians**

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Patient: _____ DOB: _____ MR#: _____ Date: _____

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? _____

_____

_____

What medications are you currently taking? Include any blood thinning over the counter agents such as aspirin, Motrin, Orudis, Aleve, Relafen, Lodine, ibuprofen, or naproxen. If you have a list, please let us make a copy of your list.

_____ _____

_____ _____

_____ _____

_____ _____

What medication allergies do you have? Please include the type of reaction you experienced:

_____

_____

Please list medical problems that are currently being treated by another physician (i.e. Hypertension, Heart Attack, Emphysema, etc.):

_____ _____

_____ _____

_____ _____

Please list any surgeries you have had in the past and the approximate dates:

_____ _____

_____ _____

Have you or any family member had any adverse reactions to general anesthesia? If yes, please explain: _____

_____

Have you received radiation in the past? Yes _____ No _____ Why? _____ When? _____

Do you or have you ever smoked? Yes _____ No _____ If so, for how long? _____ How much? _____ Currently Smoking? _____

Have you ever chewed tobacco? Yes _____ No _____ If yes, for how long? _____ Currently chewing? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If yes, how many drinks per day? _____ OR per week _____

Do you use any other "recreational drugs"? Yes _____ No _____

Please list any other information you think your physician should know about your health:

_____

_____

_____

_____

AUSTIN ENT ASSOCIATES

WELCOME TO OUR PRACTICE

New Patient Questionnaire

Adults 18 and older

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Please explain
General	Fever/chills Fatigue Weight change			
Eye	Change in vision Glasses Cataracts or glaucoma			
Ear, Nose, & Throat	Nosebleeds Sore throat or tonsillitis Hoarseness Swallowing problems Hearing problems Dizziness or Vertigo Sinus or nose problems Tinnitus (ears ringing)			
Allergy	Seasonal Hayfever Food reactions Allergy shots Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Chest pain or palpitations Congestive heart failure Heart disease or surgery High blood pressure Coronary artery disease High cholesterol/triglycerides			
GI	Acid reflux / heartburn Abdominal pain Peptic ulcer disease Hepatitis / jaundice			
GU	Prostate problems GYN problems			
MS	Arthritis problems Back or neck problems Muscle weakness Gout			
Skin	Hives or rashes Eczema Breast disease			
Neurologic	Stroke Seizures Headaches or Migraines Neurologic problems			
Endocrine	Diabetes Thyroid problems Pituitary or adrenal problems Perimenopausal symptoms			
Psyche	Depression Anxiety			
Immune	Bleeding disorders Anemia problems Enlarged lymph nodes HIV / AIDS			

FINANCIAL POLICY

Co-Payments and payment for services not covered by your insurance will be due at your visit. For your convenience, we accept cash, check, debit or credit card (MasterCard, Visa, Discover, and American Express).

Private pay patients are expected to pay in full at the time of the service. Payment for a limited new patient visit will be collected before you are called back to see the physician. An additional fees for services will be collected at checkout.

We do not accept insurance forms in lieu of payment but will provide you with a receipt that will assist you in collecting payment from your insurance carrier. We are providers for several PPO and HMO insurance plans. If we are providers under your plan, we will file your claim for you if you provide proof of insurance (insurance card). **You are responsible for obtaining necessary referrals prior to your visits or you will be asked to reschedule your appointment.** All health plans are not the same and do not cover the same services. In the event your health plan determines that a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will expect payment from the adult accompanying a minor for all services rendered to minor patients.

We do not file third party insurance for your motor vehicle accidents or liability claims. We do not wait for claims to be settled in or out of court. We expect payment from you until a settlement is made.

Medicare: We will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your deductible if not met at the time, as well as your 20 percent.

Please sign here that you have read this office policy and agree to it. If there is a problem, please speak to the cashier before seeing the doctor.

x _____ _____

Patient or Parent/Guardian Signature Date

RELEASE INFORMATION

I hereby authorize Austin ENT Associates to furnish medical information concerning my present illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Austin ENT Associates.

x _____ _____

Patient or Parent/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I request payment of the surgical and/or medical benefits, otherwise payable to me, directly to Austin ENT Associates for services provided by them. I understand that I am financially responsible to Austin ENT Associates for charges not covered by this Assignment of Benefits.

x _____ _____

Patient or Parent/Guardian Signature Date

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by Drs. Scholl, Austin, Zapalac and/or Ratcliff.

x _____ _____

Patient or Parent/Guardian Signature Date