WELCOME TO OUR PRACTICE
New Patient Questionnaire
Children 17 or younger

Today's date: ______________________ MR#: ____________

PATIENT INFO: 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 ____________

PARENT/GUARDIAN INFO: Parent/Guardian name(s) ______________________________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Name of person child currently lives with ____________________ Relationship ____________

Are you employed? Yes _____ No _____ Retired _____ If yes, name of Employer ____________

Occupation ______________________________

Employer Address ____________________ Phone ____________

If married, Spouse/Partner's name ____________ Spouse/Partner's work # ____________

Spouse/Partner Employer's name & address ______________________________

Best e-mail 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

The Pharmacy you normally use ____________________ Phone ____________

Name of nearest relative not living with you ____________________ Relationship ____________

Address ____________________ Phone ____________

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: ❑ Friend ❑ Physician ❑ www.austinentassociates.com ❑ Internet

❑ Other ____________ Have you or any of your family been previous patients? ❑ Yes ❑ No

If yes, name of patient ____________________ When? ____________

Referring Physician ____________________ Phone ____________

Primary Care Physician ____________________ Phone ____________

Dentist ____________________ Phone ____________

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Patient: ______________________ DOB: ______________________ Date: ____________

Your child's medication, medication allergies, and past health problems are an important part of their diagnosis and treatment plan. Please try to answer all questions fully.

What kind of problem is your child having? ____

What medications is your child currently taking? (If you have a list, please let us make a copy of your list.)

What medication or contact allergies does your child have? Please explain the type of reactions your child has experienced.

Please list any medical problems that your child has:

Please list any surgeries your child has had in the past and the approximate dates:

Has your child or any family member had any adverse reactions to general anesthesia? If so, please explain.

Does anyone smoke in the home? Yes _____ No _____

Does your child go to daycare? Yes _____ No _____

How many other children are there in your household? _______ What are their ages? ____________________

Birth History:

Was your child born at term? Yes _____ No _____

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

 Physician Initials _____ Date _________

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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			

Physician Initials ______ Date __________

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