WELCOME TO OUR PRACTICE
AUSTIN ENT ASSOCIATES

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 _____ Work Phone _____

(If patient is a minor, give parent/guardian employment information)

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

Occupation/Job Description _____

Employer Address _____ Phone _____

If married, Spouse's name _____ Spouse's work # _____

Spouse's Employer name & address _____

If the patient is a minor, parent(s) name(s) _____

Name of person child currently lives with _____ Relationship _____

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: ❑ 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**

WELCOME TO OUR PRACTICE

New Patient Questionnaire

Children 17 or younger

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:

_____

_____

_____

_____

AUSTIN EAR, NOSE AND THROAT ASSOCIATES
NEW PATIENT QUESTIONNAIRE

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	Comments
General	Fever/chills Weight change			
Birth	Premature birth Difficult delivery Jaundice			
Ear, Nose, & Throat	Nosebleeds Tonsillitis Ear infections Hearing loss Hearing aid use Inner ear problems Enlarged lymph nodes			
Allergy	Hayfever Animal reactions Food reactions Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Heart disease High blood pressure			
GI	Acid reflux / heartburn Colic Diarrhea / constipation Hepatitis / jaundice			
Eye	Glasses Eye Surgery			
MS	Arthritis Back problems Neck injury Muscle weakness			
Skin	Hives or rashes Eczema			
Neurologic	Seizures Developmental delay Neurologic problems Speech delay Migraines			
Endocrine	Diabetes Thyroid problems			
Psychiatric	Behavioral problems ADHD Depression Anxiety			
Immune	Bleeding disorders Hereditary anemia			

Physician Initials _____ Date _____

FINANCIAL POLICY

- Please Read Carefully -

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).

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