ADULT MEDICAL HISTORY FORM

NAME (PLEASE PRINT):_____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____ PHARMACY: _____ _____

PAST ILLNESSES OF YOURSELF (PLEASE CIRCLE EACH ITEM AS IT RELATES TO YOUR HEALTH):

ALCOHOLISM	HIGH BLOOD PRESSURE	ANEMIA	ASTHMA
KIDNEY DISEASE	SUICIDE ATTEMPT	LIVER DISEASE	TUBERCULOSIS, TB
HEPATITIS	THYROID DISEASE	CANCER/TUMOR	LUNG DISEASE
DIABETES	MENTAL ILLNESS	OSTEOARTHRITIS	DEPRESSION
HIGH CHOLESTEROL	EPILEPSY/SEIZURES	OSTEOPOROSIS	HIV/IMMUNE DX
GLAUCOMA	RHEUMATIC ARTHRITIS	SLEEP APNEA	HEART DISEASE
STROKE	OTHER_____		

FAMILY ILLNESSES (BLOOD RELATIVES):_____

_____

_____ ☐ ADOPTED, UNKNOWN

PAST SURGICAL HISTORY (PLEASE INCLUDE DATES):_____

_____

_____ ☐ BLEEDING PROBLEMS ☐ ANESTHESIA PROBLEMS

HEIGHT: _____ **WEIGHT:** _____

REASON FOR APPOINTMENT TODAY (EAR, NOSE OR THROAT):_____

_____

CURRENT MEDICAL PROBLEMS (PLEASE CIRCLE EACH ITEM AS IT RELATES TO YOUR HEALTH):

CONSTITUTIONAL:	Weight loss, Fatigue, Fever, Chills, Difficulty sleeping
EYES:	Glasses/Contacts, Eye pain, Double vision, Cataracts
ENT:	Difficulty hearing, Ringing in ears, Vertigo, Sinus trouble, Nasal stuffiness, Frequent sore throat
CARDIOVASCULAR:	Murmur, Chest pain, Palpitations, Shortness of breath, Swelling ankles
RESPIRATORY:	Cough, Coughing blood, Wheezing
GASTROINTESTINAL:	Heartburn/Reflux, Nausea/Vomiting, Abdominal pain, Black or bloody BM
GENITOURINARY:	Burning/Frequency, Blood in urine, Abnormal discharge, Bladder leakage
MUSCULOSKELETAL:	Joint Pain/Swelling, Stiffness, Muscle pain, Back pain
SKIN:	Rash/Sores, Lesions, Itching/Burning
NEUROLOGIC:	Loss of strength, Numbness, Headaches, Tremors, Memory loss
PHYSCHIATRIC:	Anxiety/Depression, Mood swings, Difficulty sleeping
ENDOCRINE:	Loss of hair, Heat/Cold intolerance
HEMATOLOGY/LYMPH:	Easy bruising, Gums bleed easily, Enlarged glands
ALLERGIC/IMMUNOLOGIC:	Hives/Eczema, Hay fever

OTHER: _____

CURRENT MEDICATIONS (INCLUDE BIRTH CONTROL PILLS, VITAMINS, AND SUPPLEMENTS):_____

_____

_____

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS OR FOODS (PLEASE INDICATE TYPE OF REACTION):_____

_____

_____ ☐ NO KNOWN ALLERGIES

SOCIAL HISTORY

____MARRIED ____SINGLE ____DIVORCED ____WIDOWED NO.OF CHILDREN: _____ OCCUPATION: _____

TOBACCO USE: YES / NO IF YES, HOW MUCH? _____/DAY HOW LONG? _____ QUIT DATE_____

ALCOHOL USE: YES / NO HOW MUCH PER DAY? _____

PATIENT SIGNATURE: _____ DATE: _____

Dallas ENT Group
7777 Forest Ln, Suite B107 Dallas, TX 75230
Phone: 972.566.8300 Fax: 972.566.8004
www.dallasentgroup.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Dallas ENT Group originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Dallas ENT Group *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Dallas ENT Group has the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I request it. I understand that I have the right to restrict the use and/or disclosure of my protected health information for treatment, payment, or healthcare operations and that Dallas ENT Group is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Dallas ENT Group has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my protected health information:

_____

_____

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to:

Name:_____ Name:_____

Name:_____ Name:_____
(Please make sure if the patient is a minor that you have included any family members you would like for us to share information with.)

I have been provided and reviewed the Dallas ENT Group *Notice of Privacy Practices.* I understand that if I have any questions or complaints, I may contact the practice's HIPAA Compliance Officer at 972-566-8300.

Printed Name:_____

Signature:_____ Date:_____

If not patient, relationship to patient:_____
If you are the patient's Power of Attorney, please provide us with documentation for our records.

DALLAS
ENT
GROUP

Patient Registration Form

Patient Name:_____ Today's Date:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

**I give consent to have appointment reminder texts sent to my cell phone. ☐Yes ☐No

Address:_____

City:_____ State:_____ Zip:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: M F

Occupation:_____ Employer:_____

Email Address:_____

Emergency Contact:_____ Relationship:_____

Phone: (_____)_____

Primary Doctor:_____ Phone: (_____)_____

Whom may we thank for referring you to our practice?_____

Who is the primary policy holder on the insurance?_____

His/Her Date of Birth:_____/_____/_____

If patient is a minor:

Mother's Name:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Father's Name:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical and surgical benefits to Dallas ENT Group.

Signature:_____ Date:_____

Patient or Legal Representative

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PATIENT PAYMENT POLICY

Thank you for choosing Dallas ENT Group for your treatment and care. We understand that medical bills can be costly and unexpected; therefore, we try to make the payment process as easy on you as possible.

Do you file to my insurance?

We file to your insurance company as a courtesy to you. We will attempt to verify your insurance benefits before each visit so that you are aware on any charges you may incur beforehand. It is important to understand that some co-insurance amounts are not able to be determined until insurance pays on a claim. Any statement you receive from our office is sent to you as a request for payment, not as a notification of insurance payment. If you are receiving a statement from our office, it is because your insurance has said that the amount owed is your responsibility. If you are questioning the bill, you may contact your insurance company directly to find out why they have applied the amount to your out of pocket expenses. You may also contact our billing office.

Do I need a referral?

If you have an HMO plan with which we are contracted, you may need a referral authorization from your primary care physician. Our office will attempt to obtain a referral prior to your visit, but if we have not received one at the time of your visit, you will be charged for the visit.

How may I pay?

Our office accepts payments by cash, Visa, Mastercard, American Express, and Discover. It is our policy not to accept checks; however, if that is the **only** form of payment you have for your visit, we will accept it. There will be a $30 charge on any returned checks for insufficient funds, and our office may seek legal action. If an account is not paid within 90 days from the date of service, a $20 service fee will be added to the total amount owed.

Do you take Care Credit?

Our office does accept Care Credit as a form of payment. Care Credit is a medical credit card that enables you to pay your bills at 0% interest, and you are able to apply in the comfort of your own home at CareCredit.com. Our office does charge a one-time fee of 9% of the balance paid by Care Credit. If you have any questions about Care Credit or wish to sign up, please ask to speak to one of our billing specialists.

What about in-office surgery charges?

As a convenience, some procedures are able to be performed in office, saving you the expenses of anesthesia and facility fees. These procedures, including Nasal Endoscopies and Laryngoscopies, may be processed by your insurance company differently than an office visit would be and apply to a different set of deductibles and co-payments.

Do you charge for Medical Records?

Our office may charge for certain medical records that are sent. Some records sent for continuing treatment are complimentary. Federal disability forms are charged $18. Complete medical records are $25, and any records being requested by law firms where we may be a witness for you in a law suit are $50.

I acknowledge that I have read, understand, and will comply with these payment policies.

Signature:_____Date: _____
Patient, Guarantor, or Legal Guardian