

DALLAS ENT GROUP
PATIENT REGISTRATION

Patient Name _____ Sex _____ Birth Date _____
Address _____ City _____ St _____ Zip _____
Home Phone(_____) _____ Cell(_____) _____ Work(_____) _____
SSN _____ TXDL# _____ Email address _____
Employer (if patient is adult) _____

Information Required if Patient is a child

Mother's Name: _____ DOB _____ SS# _____
Mother's Employer: _____ Work # _____
Father's Name: _____ DOB _____ SS# _____
Father's Employer: _____ Work # _____

Primary Insurance Information

Insurance Company _____ ID # _____
Address _____ Grp # _____
Policy Holder _____ Birth Date _____ Relation to patient _____

Secondary Insurance Information

Insurance Company _____ ID# _____
Address _____
Policy Holder _____ Birth Date _____ Relation to patient _____

Contact Person whom we might call to reach you:

Name _____ Relationship _____ Phone (____) _____

Please be aware that this office operates on a cash basis.

How do you intend to pay for today's services? Cash _____ Charge _____

Patients with an insurance "CO-PAY" are required to pay "CO-PAY" at the time the service are rendered.

All others will be asked to pay the balance of charges, as services are rendered.

I have read the above information. I accept responsibility that all information given is correct.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/surgical benefits, to including major medical benefits to which I am entitled, private insurance, and any other health plan to Dallas ENT Group, Timothy H. Trone, M.D, Dr. Thomas Y.L. Hung, M.D, or Dr. Andy T.A. Chung, M.D.

Signed: _____ Date: _____

Patient or Guardian (if minor)

Dallas ENT Group

Pediatric Ambulatory History

Today's Date _____

Patient Name _____ DOB _____ Age _____

Pharmacy Name and Phone _____

Referring Physician or Practioner _____

What is the reason your child is being evaluated?

How long has he/she has this problem?

Please respond for all infants less than one year of age or those infants that experienced neonatal complications:

Was the infant full term? _____ Gestational age at birth. _____

Birth weigh _____ Present Weight _____

Problems during pregnancy? _____ Please describe. _____

Days spent in the neonatal nursery _____

Was your child admitted to the Neonatal Intensive Care .
If yes, how long and for what reason?

Did your child pass the hearing screen in the Newborn nursery?

Please respond for all infants and children:

Present medications: _____

Allergies to medications: _____

Previous surgery: _____

Previous hospitalizations: _____

Please list and explain if your child has experienced problems with the following:

- Vomiting
- Choking
- Recurrent Pneumonia or RSV
- Persistent Cough
- Mouth Breathing and/or snoring
- Cyanotic episode (turning blue)
- Airway noise (anytime)
- Airway noise after eating
- Wheezing
- Recurrent ear infections or drainage
- Recurrent nasal infection with yellow-green nasal drainage
- Speech or Language delay
- Bleeding problems or family history of bleeding problems?
- Problems with anesthesia or family history of anesthesia problems?

Is your child under the care of another Pediatric Specialist? _____ If so, please explain.

PATIENT SIGNATURE (Parent, if minor) _____ relationship _____

DALLAS ENT GROUP

Medication Policy

Our patients are very important to us. Our goal at **Dallas ENT Group** is to provide you with the best treatment possible in a pleasant and caring manner. We are sensitive to the pain you may be experiencing and for that reason, your doctor may give you medication to help with your pain.

1. Medications should be taken as instructed by your doctor.
2. Contact your pharmacy for all medication refills.
3. If you take all medication before it is time for a refill, the refill request will be denied.
4. Medication refills will not be done after 4:30 P.M. Requests after that time will be done the next business day.
5. Medications will not be filled on the weekend or by the on-call doctor.
6. For our surgery patients, all physician will not refill pain medication:
 - 4-6 weeks after a Nasal/Sinus Surgery or Sleep Apnea Surgery.
7. It is our policy not to prescribe narcotics for undiagnosed pain.
8. If medication is needed beyond the normal post-operative period, or if pain persists after completion of non-surgical treatment, you will be referred to a pain management program so that a team of specialists can help you with your persistent pain. At this point, you will be given all pain medications from the pain specialists and not from our office. The pain specialist will keep our office notified of your progress.
9. **By initialing (____), I give consent to access PHR, or Patient Health Records.**

I have read and understood the policy or it has been explained to me.

Patient's Printed Name

Date

Patient's Signature

Witness

Agreements and Authorization

Insurance

If you have medical/dental insurance, your financial responsibility depends on the coverage provided by your policy. Patients with insurance are responsible for paying any co-payment (and you may also be asked to pay fee(s) for deductibles, co-insurance and non-covered services) at the time the service is provided. Your plan may have special requirements, such as pre-certification or referrals for certain procedures or tests. It is your responsibility to know and understand your individual benefit package.

We will submit a claim to your insurance company, provided you supply all the required information. If your insurance company fails to pay within a reasonable amount of time, you will be expected to pay for the service. _____ (Initials)

Surgical Procedures done in the office:

I understand that any procedures done in the office may be covered under different benefits and that I may owe an additional amount. Example: Nasal endoscopy and laryngoscopy is a surgical procedure and insurance may process charges differently. If you have any questions please ask the medical assistant and she will get an employee to answer your questions. This signature applies to any visit that I am seen in the office. _____ (Initials)

Delinquent Accounts

We refer delinquent accounts to outside collection agencies for recovery when full payment has not been received after a prescribed number of written and verbal contacts with you or the responsible party. Should it become necessary for us to refer your account to a collection agency, you will be responsible for any fees incurred and charged to us by the collection agency for recovery on your delinquent account balance. You may also be assessed a late payment interest charge of 6% per month, calculated at simple interest, on your delinquent balance. In addition, you may be responsible for court costs and attorney fees incurred to collect this debt.

In the event you issue a check that is issued but not honored and paid by your financial institution, you will be charged a \$25.00 returned check fee. _____ (Initials)

Financial Agreement: Our charges from us will be combined into one bill. You are responsible for paying your bill in full by the designated due date on the billing statement. If you have a question about your bill or are unable to pay the balance in full, please contact us. The undersigned agrees, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself to pay the account of North Dallas ENT Group in accordance with the regular rates and terms of the North Dallas ENT Group. The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ (Initials)

By signing below, I acknowledge, understand, and agree to the above information.

Patient Signature Date Responsible Party Signature Relationship

ACKNOWLEDGEMENT OF RECEIPT

By my signature below, I acknowledge that I have received the Practice's *Notice of Privacy Practices* on or prior to any service being provided to me by the Practice following April 14, 2003, and consent to the use and disclosure of my medical information as set forth herein.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

I hereby request the following restrictions on the use of my information: _____

