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?_____________________________________

Primary Insurance Company:____________________ Secondary Insurance Company: df_________________

Name of Insured:________________DOB:________ Name of Insured:________________ DOB:________

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

ADULT MEDICAL HISTORY FORM

NAME (PLEASE PRINT)**:**____ DATE OF BIRTH: ______________________________

REFERRING PHYSICIAN: ______________________________________ PHARMACY: ______________________ ___________________

PAST ILLNESSES OF YOURSELF (Please check next to each item that applies)

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 check next to each item that applies)

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
PSYCHIATRIC: ☐ 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

12720 Hillcrest Rd, Suite 900 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.

12720 Hillcrest Rd, Suite 900 Dallas, TX 75230
Phone 972.566.8300 Fax 972.566.8004
www.dallasentgroup.com

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. 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.

What about cancellation fees?
Our office will charge a $100 cancellation fee if your surgery is cancelled within 3 business days (excluding weekends and holidays) of the surgery date unless there is a medical necessity for the cancellation. In the event there is a medical necessity to reschedule, we will be happy to find another date that works with your schedule.

Do you charge for physician after-hours calls?
The physicians of Dallas ENT Group are available after hours to respond to any post surgical related emergencies. All other non-emergent calls to the physician after-hours will result in a $50 charge.

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

Signature:____ Date: ________________
Patient, Guarantor, or Legal Guardian