PLEASE PRINT

PATIENT REGISTRATION FORM

TODAY'S DATE ____________________

IF REFERRED BY A DOCTOR GIVE NAME & PHONE # ____________________

■ **PATIENT'S** NAME ____________________
Last First M.I.

HOME ADDRESS ____________________

CITY, STATE, ZIP ____________________ AGE ________ GENDER ☐ MALE ☐ FEMALE

BIRTH DATE ____________________ MARITAL STATUS ____________________

HOME PHONE # ____________________ SOCIAL SEC. # ____________________

CELL PHONE # ____________________ DRIVERS LIC. # ____________________

EMAIL ADDRESS ____________________

■ **EMPLOYER** NAME ____________________ WORK ADDRESS ____________________

CITY, STATE, ZIP ____________________ WORK PHONE # ____________________

■ **INSURED'S** NAME ____________________ SS No: ____________ **BIRTH DATE** ____________
(If different than patient)

EMPLOYER NAME ____________________ WORK ADDRESS ____________________

CITY, STATE, ZIP ____________________ WORK PHONE # ____________________

EMERGENCY CONTACT NAME & PHONE # ____________________

PREFERRED PHARMACY NAME & PHONE # ____________________

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION:

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.

FATHER'S NAME ____________________ BIRTH DATE ____________________

SOCIAL SEC # ____________________ DRIVERS LIC # ____________________

ADDRESS ____________________

CITY, ST, ZIP ____________________ HOME PHONE # ____________________

EMPLOYER ____________________ WORK PHONE # ____________________

MOTHER'S NAME ____________________ BIRTH DATE ____________________

SOCIAL SEC # ____________________ DRIVERS LIC # ____________________

ADDRESS ____________________

CITY, ST, ZIP ____________________ HOME PHONE # ____________________

EMPLOYER ____________________ WORK PHONE # ____________________

Patient Medical History

Please provide the following confidential information regarding your medical history. Thank you.
This information should be updated ANNUALLY or with any changes to your medical history.

Name: ______________________ Age: ________

Reason for appointment: ______________________

- Who is your **referring physician?** ______________________
- **Current medications?** ☐ No ☐ Yes; please list: ______________________
- Are you pregnant? ☐ No ☐ Yes; how many months? ______________________
- **Medical History.** Which medical conditions apply to you? Please provide a brief explanation.

	NO	YES	Explanation
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding / Blood Disease	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease / Murmur	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney / Urinary	☐	☐	
Liver problems / Hepatitis	☐	☐	
Nervous Disorders	☐	☐	
Seizures or Epilepsy	☐	☐	
Stomach problems	☐	☐	
Thyroid Disorders	☐	☐	
Other	☐	☐	

- **Allergies** to medicine? ☐ No ☐ Yes; please list: ______________________
- **Previous surgeries?** ☐ No ☐ Yes; please list: ______________________

■ **Family History.** Which medical conditions apply to your family? Please provide a brief explanation.

	DAD	MOM	SIBLING	CHILD	OTHER	EXPLANATION
Arthritis	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	
Bleeding / Blood Disorders	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Heart Disease / Murmur	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	
Kidney / Urinary	☐	☐	☐	☐	☐	
Liver problems / Hepatitis	☐	☐	☐	☐	☐	
Nervous Disorders	☐	☐	☐	☐	☐	
Seizures or Epilepsy	☐	☐	☐	☐	☐	
Stomach problems	☐	☐	☐	☐	☐	
Thyroid Disorders	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

■ **Occupation.** ______________________________

■ Do you use tobacco? ☐ No ☐ Yes ☐ Former Smoker Number of packs per day? __________
Number of years? __________

■ Do you drink alcohol? ☐ No ☐ Yes How many drinks a week? __________

■ **Currently,** do you have any of the following symptoms? (Please mark those that apply)

- ☐ Seasonal allergies
- ☐ Cough
- ☐ Shortness of breath
- ☐ Fever
- ☐ Weight loss
- ☐ Rash on skin
- ☐ Temperature intolerance
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Ear blockage
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Facial pain
- ☐ Nasal congestion
- ☐ Nasal drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Lumps and nodules
- ☐ Snoring
- ☐ Nosebleed
- ☐ Problems swallowing
- ☐ Heartburn or indigestion
- ☐ Swollen glands
- ☐ Bruise or bleed easily
- ☐ Muscle or joint pain
- ☐ Headache
- ☐ Numbness/Weakness
- ☐ Visual disturbances

■ **Height and weight?** _____ft. _____in. ______pounds

■ **Pharmacy Name and Phone Number?** ______________________________

I certify that the above information is complete and accurate.

Patient's Signature: ______________________________ Date: __________

The Center for **ENT**

Otolaryngology – Head & Neck Surgery

Sam C. Weber, MD, FACS
Ron L. Moses, MD, FACS
Richard T. Hung, MD, FACS
Eric S. Powitzky, MD, FACS
Brett M. Cordes, MD
Kristin K. Marcum, MD
S. Ross Patton, MD

Notice of Privacy Practices
Acknowledgment

You have been given the Notice of Privacy Practices for The Center for ENT and its Physicians. This notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of The Center for ENT with respect to health information created for services generated by The Center for ENT. If you receive services by your physician or other health care providers at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicates that you have been provided with a copy of this Notice of Privacy Practices.
If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call our Practice Administrator at 713-795-5343.

Patient Name: ______________________________

Signature of Patient
or Responsible Party: ______________________________

Date: ______________________

- **CONTACTS:** Please list other persons that we may inform about your health information

  ______________________ ______________________

- **PHONE NUMBER:** At which phone numbers would like you to receive calls about appointment, financial, or medical conditions information? [check all that apply] We may leave a voice mail? ___Yes ___No

___Home Phone ___Cell Phone ___Work Phone ___ Other Phone: ______________

Patient Signature: ______________________________

Patient Consent for Use of Email Communication

To better serve our patients, The Center for ENT allows patients to communicate with our staff via Email. Prior to doing this, you must read through and sign this Email policy. Email should only be used for routine matters that do not require an immediate response. **Should you require urgent or immediate attention, Email is not appropriate.** We strive to respond to all Email communication within **2 business days.** If a response is not received within the expected timeframe, please call our office for immediate assistance.

When communicating via Email, **please put the purpose of your message in the subject line so that we may process it more efficiently. Also, be sure to include your name, date of birth, and return phone number in the body of your message.** We also ask that you acknowledge receipt of Emails coming from our office by using the auto reply feature.

All Email communications related to your health and treatment may be filed in your medical record. The Center for ENT is not liable for improper disclosure of information, breaches of confidentiality caused by the patient (i.e. printing or forwarding Emails), third parties, or technical factors beyond the Practice's control. In addition, The Center for ENT has no control over security or management of third party Email systems, if used. The patient understands and agrees that The Center for ENT will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee that unencrypted information will not be intercepted, altered, or read by an unintended patient.

I understand that The Center for ENT is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond the Practice's control. By signing below, I am agreeing that The Center for ENT may send medical related correspondence to me via Email, and may respond to my Emails via Email.

Patient Signature ______________________________ Date ______________

Revised: June 6 2016

POS Reorder # 1007617

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Thank you for choosing The Center for ENT.

In order to track Meaningful Use of our Electronic Medical Record, we are required to maintain the information below as part of your personal medical record.

As with all of your medical information, this will be maintained CONFIDENTIALLY.

Patient Name: ____

Email Address: ________________________________@__________________

*We will grant you access to our patient portal for electronic messaging and access to portions of your health record. We will NOT share your email address with any other parties.

Primary Language: (Check One)

____ ENGLISH
____ SPANISH
____ INDIAN (Includes Hindi & Tamil)
____ RUSSIAN
____ OTHER: ___________________________

Race: (Check One)

____ American Indian or Alaska Native
____ Asian
____ Native Hawaiian or Other Pacific Islander
____ Black or African American
____ White
____ Hispanic
____ Other Race
____ Unreported / Prefer Not to Answer

Ethnicity: (Check One)

____ Hispanic or Latino
____ Not Hispanic or Latino
____ Prefer Not to Answer

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Financial Policy

Welcome to The Center for ENT! We are committed to providing you with quality medical care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. ***Please ask if you have any questions about our fees, financial policy, or your responsibility.***

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE RECEPTIONIST WHEN YOU SIGNIN FOR YOUR APPOINTMENT.

SELFPAY/ CASH PAY POLICY

For patients who are not using insurance for their office visit, a **$200 deposit will be due at CHECK-IN.** This deposit will be applied to the actual charges at check-out. If the visit charges exceed $200, the remaining balance will be due at check-out. In the event the actual charges are less than $200; the difference will be refunded at check-out.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to your contract though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance company regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. **You are responsible for timely payment of your account and office visit claim follow-up with your insurance company.** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

Medicare: We are participating providers with Medicare. We will also file with your secondary or supplementary policy.

Contracted Managed Health Care: (HMO's, PPO's, EPO's) **It is your responsibility to make sure that the Physician(s) you will see is currently enrolled with your plan. All necessary referrals must be obtained prior to each visit.** If a referral is not completed or obtained prior to your appointment, it may result in a delay or possibly rescheduled.

Worker's Compensation: We **DO NOT ACCEPT** Worker's Compensation patients as of 07-01-2002.

Minors/Unaccompanied Minors: The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status.

ADDITIONAL POLICIES

Initials	Policy
______	**Scheduling Fees:** A **$100 scheduling fee** is required to reserve your **in- office procedure/surgery or outpatient surgery time**. If your in-office procedure/surgery or outpatient surgery is cancelled with less than a one week's notice for a non-medical reason, the scheduling fee is non-refundable. If the in-office procedure/surgery or outpatient surgery is performed as scheduled, the fee will be applied to your final remaining balance. A **$25 scheduling fee** is required to reserve your time for **allergy testing**. If your allergy test is cancelled with less than a 72 hour notice for a non-medical reason, the scheduling fee is non-refundable. If the allergy test is performed as scheduled, the fee will be applied to your final remaining balance.
______	**Form Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: FMLA, Immigration, and disability forms **$25**. Copies of your pertinent medical information will be provided to you for a fee of **$25** Medical record copies forwarded to other physicians involved in your healthcare are provided free of charge.
______	**Collection Fees, Bank Fees, and Credit Reporting:** Accounts more than 90 days old are subject to a $25 collection fee and report to the credit bureau. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $25.

I have read and understand the above terms and conditions and by my signature below, I attest that I fully understand each item and agree to the terms above.

______________________________ ______________________

Signature Date

______________________________ ______________________

Printed Name Social Security No:

Physician Disclosure of Financial Interest

______________________________________ ______________
(Patient Name) DOB

The Center for ENT and individual physicians, have a financial interest in several medical entities. Therefore, the Center for ENT physicians stands to benefit financially if you have services performed at these facilities or pharmacy. Listed below is a list of the area medical entities that I or The Center for ENT has financial interest in:

The Center for ENT Providers

Premier Audiology &
Hearing Aid Center
6624 Fannin St. Suite 1482
P: (713) 328-0828
F: (713) 328-0830

The Center for Allergy and Sinus
6624 Fannin St. Suite 1460
Houston, Texas 77044
P: (713) 790-1272
F: (713) 512-8383

Sigma Pharmaceutical Consulting Group, LLC
Webster Pharmacy
15610 Hwy 3
Webster, TX 77598
P: (281) 886-7164
F: (281) 652-5345

Dr. Sam Weber
Apnix Sleep Diagnostic
4003 Bellaire Blvd
Houston, TX 77025
P: (713) 349-9767
F: (713) 349-9634

Dr. Ron Moses
Dr. Eric Powitzky
First Nobilis LLC, DBA,
First Street Surgical Hospital
411 N. First Street
Bellaire, TX 77401
P: (713) 665-1111
F: (713) 665-4146

Dr. Eric Powitzky
MH Surgery Center Kirby, LLC
2459 S. Braeswood Blvd
Houston, Texas 77030
P: (713) 590-8600
F: (713) 590-8603

Patient: You have the option to be treated at the healthcare entity of your choice.

You will not be treated differently if you choose to obtain your care at any of the entities listed on this page. By signing below, you, or your legal representative, acknowledge that is disclosure has been made in advance, and that your provider has not referred you to any specific entity to receive treatment.

____
Signature of Patient

____
Signature of Parent or Guardian
(if applicable)

____
Type or Print Name of Patient

____
Type or Print Name of Parent or Guardian
(if applicable)

Date:______________________

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