The Center for ENT
Otolaryngology – Head & Neck Surgery

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Patient Registration Form

Today's Date: _____ If referred by a doctor give name & phone no.: _____

PATIENT INFORMATION				
Last name:	**First name:**			**M.I.:**
DOB:	**Age:**	**Sex:** M: ☐ F: ☐	**Marital Status:**	**Drivers Lic. #:**
Address:	**City:**		**State:**	**Zip Code:**
Home phone no.:	**Cell phone no.:**			
Contact Email:				
Employer:	**P:**		**F:**	
Address:	**City:**		**State:**	**Zip Code:**
Emergency Contact Name:	**P:**		**Relationship:**	
Primary Care Physician:	**P:**		**F:**	
Preferred Pharmacy:	**P:**		**F:**	
Address:	**City:**		**State:**	**Zip Code:**

PRIMARY INSURANCE INFORMATION	
Subscriber Name:	
DOB:	
Primary Insurance:	
Policy #:	**Group #:**
Employer:	

SECONDARY INSURANCE INFORMATION	
Subscriber Name:	
DOB:	
Primary Insurance:	
Policy #:	**Group #:**
Employer:	

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.

**** We will grant you access to our patient portal for electronic messaging and access to portions of your health records. ****
*** 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: _____
- ☐ Unreported I Prefer Not to Answer

ETHNICITY: (CHECK ONE)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Answer

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 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 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: _____

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

_____ _____

PHONE NUBMER: 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: _____

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 an **in- office procedure/surgery or outpatient surgery time**. If an 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. **No Show/Missed Appointments or Late Appointments:** If it is necessary for you to cancel your appointment, we ask that you contact the office 24 hours in advance. If you are a no show or missed appointment you will be charged a $25.00 no show/missed appointment fee. If you arrive more than 15 minutes late for an appointment, we reserve the right to reschedule your appointment.
_____	**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.

☐ Check to Acknowledge

Date: _____

Patient Name: _____

Signature of Patient or Responsible Party: _____

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: _____ Referring Physician: _____
Reason for appointment: _____

- **Current Medications:** ☐ No ☐ Yes; Please list:

1	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
2	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
3	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
4	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**

- **Height:** _____ft. _____in. **Weight:** _____
- **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:

1	**Name of medication:**
2	**Name of medication:**
3	**Name of medication:**
4	**Name of medication:**

- **Previous surgeries?** ☐ No ☐ Yes; Please list:

1	
2	
3	
4	

- **Family History.** Which medical conditions apply to you? Please provide a brief explanation.

	DAD	MOM	SIBLING	CHILD	OTHER	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	☐	☐	☐	☐	☐	

- **Occupation:** _____
- **Do you use tobacco?** ☐ No ☐ Yes ☐ Former Smoker
  No. of packs per day? _____ No. 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	☐ Rash on skin	☐ Ringing in ears	☐ Nasal drainage	☐ Nosebleed	☐ Muscle or joint pain
☐ Cough	☐ Temperature intolerance	☐ Hearing loss	☐ Sore throat	☐ Problems swallowing	☐ Headache
☐ Shortness of breath	☐ Ear pain	☐ Dizziness	☐ Hoarseness	☐ Heartburn or indigestion	☐ Numbness/Weakness
☐ Fever	☐ Ear drainage	☐ Facial pain	☐ Lumps & nodules	☐ Swollen glands	☐ Visual disturbances
☐ Weight loss	☐ Ear blockage	☐ Nasal congestion	☐ Snoring	☐ Bruise or bleed easily	

Patient Signature: _____ Date: _____