Austin ENT ASSOCIATES

WELCOME TO OUR PRACTICE
New Patient Form
Children 17 or younger

Today's date: _____ MR#: _____

PATIENT INFORMATION

Last name _____ First Name _____ MI _____ Sex: ❑ M ❑ F

Age _____ Birth Date _____ Social Security # _____ Driver's Lic # _____

Home Address _____

City _____ State _____ Zip _____

Parent/Guardian Name _____ Relationship _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Email address to reach you: _____

May we share your e-mail address with the hospital or surgery center if you schedule surgery with one of our physicians? ❑ Yes ❑ No

Are you employed? Yes _____ No _____ If yes, name of Employer _____

Occupation/Job Description _____

Employer Address _____ Work Phone _____

If married, Spouse's name _____ Spouse's work # _____

Spouse's Employer name & address _____

The Pharmacy you normally use _____ Phone _____

PRIMARY INSURANCE INFORMATION

❑ Medicare ❑ PPO ❑ HMO ❑ POS ❑ Private Pay ❑ Other

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

REFERRED BY: ❑ Primary Care Physician ❑ Dentist ❑ Other Physician ❑ Friend ❑ Internet ❑ Other

Have you or any of your family members been seen as patients in this Practice? ❑ Yes ❑ No

If yes, name of patient _____ When? _____

Primary Care Physician _____ Phone _____

Dentist _____ Phone _____

Physician who referred you to our Practice? _____ Phone _____

***Please be sure to include first and last name of your physicians**

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Patient: _____ DOB: _____ Date: _____

Your child's medication, medication allergies, and past health problems are an important part of their diagnosis and treatment plan. Please try to answer all questions fully.

What kind of problem is your child having? _____

_____

What medications is your child currently taking? (If you have a list, please let us make a copy of your list.)

_____

_____

Does your child have any medication allergies? Please explain the type of reactions your child has experienced.

_____

_____

Please list any medical problems that your child has:

_____ _____

_____ _____

_____ _____

Please list any surgeries your child has had in the past and the approximate dates:

_____ _____

_____ _____

_____ _____

Has your child or any family member had any adverse reactions to general anesthesia? If so, please explain.

_____

_____

Does anyone smoke in the home? Yes _____ No _____

Does your child go to daycare? Yes _____ No _____

How many other children are there in your household? _____ What are their ages? _____

Birth History:

Was your child born at term? Yes _____ No _____

Please list any other information you think your physician should know about your child's health:

_____

_____

_____

_____

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Patient _____ DOB _____ Date _____

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Comments
General	Fever/chills Weight change			
Birth	Premature birth Difficult delivery Jaundice			
Ear, Nose, & Throat	Nosebleeds Tonsillitis Ear infections Hearing loss Hearing aid use Inner ear problems Enlarged lymph nodes			
Allergy	Hayfever Animal reactions Food reactions Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Heart disease High blood pressure			
GI	Acid reflux / heartburn Colic Diarrhea / constipation Hepatitis / jaundice			
Eye	Glasses Eye Surgery			
MS	Arthritis Back problems Neck injury Muscle weakness			
Skin	Hives or rashes Eczema			
Neurologic	Seizures Developmental delay Neurologic problems Speech delay Migraines			
Endocrine	Diabetes Thyroid problems			
Psychiatric	Behavioral problems ADHD Depression Anxiety			
Immune	Bleeding disorders Hereditary anemia			

Physician Initials _____ Date _____

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PAYMENT POLICY

Insurance. It is your responsibility to understand your insurance benefits. Always confirm with your insurance company in advance that we are contracted providers with your plan. Please contact your insurance company with any questions you may have regarding your coverage. A quote of benefits is not a guarantee of benefits or payment from your insurance company.

If your insurance card has a co-pay listed on it, we will collect the specialist copay and file your claim for services rendered. Deductible may apply if you are out of network. If you have any procedures performed during your office visit and your insurance applies those services to your deductible, you will receive a statement for the balance due. Payment will be due upon receipt, or prior to any follow-up appointments, whichever comes first.

If the insurance card does not show a co-pay, that indicates that you have a deductible plan. You will be charged the insurance allowable for any services rendered and payment is expected at the time of visit. We will file your claim and issue a refund if any overpayment has occurred. If you owe an additional balance, a statement will be sent to you payable upon receipt, or prior to any follow-up appointments, whichever comes first.

If you are private pay, the charge for the first consultation is $175. If you are private pay and you are an established patient, the charge for the office visit is $135. Any additional procedures will be in addition to that. Payment is expected at the time of service.

If you are scheduled for surgery, our office will verify your insurance benefits and eligibility. An estimate of your financial responsibility will be given to you prior to your procedure. You will be expected to pay this as a surgery deposit. A refund will be promptly issued once the claim processes should an overpayment occur. If there is a remaining balance, you will be sent a statement that will be due upon receipt.

Proof of insurance. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim. We also require photo ID be presented at check-in.

Referrals and authorizations. Patients are responsible for obtaining necessary referrals and authorizations *prior to your visit*. You will be asked to reschedule your appointment or sign a waiver stating you will be responsible for the balance if the referral or authorization is not received by our office in a timely manner. It is the patient's responsibility to track the expiration date and number of referrals remaining.

Third party insurance. We do not file third party insurance for your motor vehicle accidents or any other liability claims. You are responsible for payment at time of service.

Nonpayment. Our office makes multiple efforts to inform patients of balances due. If your account is delinquent (over 90 days past due) and you have not responded to statements or phone calls, your account will be forwarded to a collection agency. Partial payments will not be accepted unless otherwise negotiated in advance.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party _____ **Date**_____

CONSENT FOR TREATMENT. I hereby authorize evaluation and treatment by the physicians of Austin ENT Associates.

Signature of patient or responsible party_____ **Date**_____

RELEASE OF INFORMATION. I hereby authorize Austin ENT Associates to furnish medical information for my current illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician (s), and my insurance companies. I further authorize my family physician, referring physician, and other healthcare providers to furnish all medical information regarding my present illness or injury to Austin ENT Associates.

Signature of patient or responsible party_____ **Date** _____

ASSIGNMENT OF BENEFITS. I request payment of the surgical and/or medical benefits, otherwise payable to me, directly to Austin ENT Associates for services provided by them. I understand that I am financially responsible to Austin ENT for charges not covered by this assignment of benefits.

Signature of patient or responsible party _____ **Date** _____

RECORDINGS, VIDEOS, PHOTOS. Here at Austin ENT we have complete respect for your privacy. We would never make an audio, photographic or video recording of you without your specific permission. We ask that you likewise agree that neither you nor anyone with you will make any audio, photographic or video recording of anyone in this clinic without their specific permission. Please indicate your agreement by signing below.

Signature of patient or responsible party _____ **Date** _____