TEXOMA ENT & ALLERGY / TEXOMA HEARING INSTITUTE

Head & Neck Surgical Associates

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1 Burnside Drive, Wichita Falls TX 76310
Telephone No: (940) 322-6953

NOTE: ***To avoid a $25.00 cancelation fee***, please give us 24 hours advanced notice when cancelling appointments.

PERSONAL INFORMATION

Today's date:_____ **PATIENT'S SSN**:_____

(PATIENT)
First Name:_____ MI: _____ Last Name:_____

Address:_____

Zip Code:_____ City:_____ State:_____

Date of Birth: ___/____/_____ Age:_____ Gender:_____ Marital Status: _____
Height: _____

Minor Patients: Name of Parent/Guardian:_____

E-mail Address: _____
Full Time Student? **o** Yes **o** No

Preferred Language:_____ Are you Hispanic/Latino **(ethnicity)**? **o** Yes **o** No

Race: **O** African/American **O** Asian **O** White **O** other (list)_____

May we leave information on your answering machine, e-mail, or voicemail? **o** Yes **o** No

Home phone number: (_____)_____ Cell Number: (_____)_____

Work number: (_____)_____

Employer: _____

In the event of an emergency, please contact:

NAME: _____

RELATIONSHIP: _____ Phone Number: (____) _____

Health Insurance Portability & Accountability Act (HIPAA): ***Please list family member(s)/friend to whom we may release medical information*:**

Name _____ **Phone** _____

Name _____ **Phone** _____

Texoma ENT & Allergy / Texoma Hearing Institute
(Head & Neck Surgical Associates)
1 Burnside Drive, Wichita Falls TX 76310

INSURANCE INFORMATION

Please present your insurance card(s) to the receptionist for her to scan.

***Please give complete information*:**

NAME OF PATIENT:_____ Date of Birth:_____

PRIMARY INSURANCE

INSURANCE CO:_____Policyholder's Name:_____

PATIENT'S relationship to policyholder: **O** Self, **O** Spouse, **O** Child, **O** Other

Policy Number: _____Group Number: _____

Employer: _____

Policyholder's SSN:_____ Date of Birth:_____

SECONDARY INSURANCE

INSURANCE CO:_____Policyholder's Name:_____

PATIENT'S relationship to policyholder: **O** Self, **O** Spouse, **O** Child, **O** Other

Policy Number:_____ Group Number:_____

Employer:_____

Policyholder's SSN:_____ Date of Birth:_____

The parent/guardian accompanying a child will be responsible for all charges.

I have read the above information, and understand and agree that I am responsible for payment of services I receive:

PATIENT/Guardian Signature: _____Date:_____

Referring Physician: _____ Phone (____) _____

Family Physician: _____ Phone (____) _____

Revised 7/19

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **This is very important information. Please fill out every item.**

Date:_____ Physician you are seeing here today: _____Insurance:_____

Patient's Name Last: _____ First: _____ MI:_____

____ Male ____Female Date of Birth: _____ Height: _____

PHARMACY PREFERENCE (include location):_____

REASON FOR YOUR VISIT:

MEDICATIONS: Please list any medications you are currently taking (if not bring your bottles/printout)

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ Yes _____ No If yes, please list below:

Name of Medication	Type of Reaction

PARENTS HEALTH STATUS: Living: (Mother_____ Father_____) Deceased: (Mother _____ Father _____)

LIST ANY SURGERIES you have had (including dates): _____

_____

_____

List year of Mammogram _____ Pap Smear _____ Colonoscopy _____

Are you up-to-date on the Flu Shot? (Y) (N); if yes, date _____
If you are over 65, have you had the Pneumonia vaccine? (Y) (N); if yes, date _____

Current Tobacco User ? (Y) (N) How many packs per day? _____ Interested in Quitting? (Y) (N)

Use of Alcohol: Never _____ Rarely _____ Frequently _____ Amount _____

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Insurance: We participate in most insurance plans. Knowledge of your insurance benefits and eligibility is patient responsibility. Any balance after Insurance has processed will be the patient responsibility. All Copayments, Coinsurance and Deductibles must be paid at the time of service. Please be aware that not all services are covered by Insurance. Non-covered services are considered patient responsibility. I give Texoma ENT & Allergy/Texoma Hearing Institute permission to file insurance on my behalf.

Payment Policy: All account balances are due at the time you receive our statement Due to the high costs of medicine, we must streamline the billing process. Therefore, you will receive 2 statements, if no payment is made the account may be turned to an outside agency for collections.

Forms: If a specific form needs to be complete, there will be a $30 fee due and payable before the form is completed (i.e. FMLA).

Release of Information: I authorize the release of any medical information needed to process a claim. I also authorize the release of medical benefits directly to the physician described. I authorize this practice to furnish medical information pertinent to my medical condition, including but not limited to diagnosis, treatment and care offered or rendered to me in regards to referrals, hospitalization and/or further testing. I agree not to hold Texoma ENT & Allergy/Texoma Hearing Institute, its agents and/or employees liable for any unfavorable outcome as a result of releasing this information.

HIPAA: I have read and understand the HIPAA policy for this practice and have listed the appropriate person/persons that I give permission to have access to my information.

NO Show: We ask for notification 24 hours in advance to cancel an appointment. There may be a $25 fee for appointments that are considered NO SHOW.

I have read, reviewed and understand the above.

Signature: _____

Date: _____