Austin Association of Otolaryngologists, P.A.

Patient Demographics and Insurance Form

Provide your insurance card and photo ID at reception.

Patient's Legal Name		*AKA*	*Today's Date*
Address		*City/State/Zip*	
Cell Phone	*Other Phone*	*Email Address*	
Date of Birth	*Social Security #*	*Sex*	*Preferred Language* ☐ English ☐ Spanish ☐_____
Marital Status ☐ Single ☐ Married ☐_____	*Race* ☐ Caucasian ☐ African American/Black ☐ Asian ☐ Other_____ ☐ Unknown/Decline to Specify		*Ethnicity* ☐ Decline to Specify ☐ Hispanic ☐ Non-Hispanic
Occupation	*Employer/School*	*Address*	
Emergency Contact Name	*Relationship*	*Emergency Contact Number*	
Guarantor (Responsible Party)	*Phone Number*	*Address*	
Name of Primary Care Physician		*PCP's Phone Number*	*PCP's City, State*
How did you hear about us? ☐ Family/Friend ☐ Insurance ☐ Internet _____ ☐ Doctor Referral, Provide Name: _____ ☐ Other			
Insurance Information	☐ *Check here if you/patient do not have insurance.*		
Insurance Company Name	*Member ID*	*Group Number*	*Insurance Phone Number*
Name of Policy Holder	*Relationship*	*Policy Holder Social Security #*	*Policy Holder Date of Birth*
Secondary Insurance Company	*Member ID*	*Group Number*	*Insurance Phone Number*
Name of Policy Holder	*Relationship*	*Policy Holder Social Security #*	*Policy Holder Date of Birth*

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I reviewed a copy of Austin Association of Otolaryngology's HIPAA Privacy Notice and Privacy Practices.

Signature Printed Name Date

Consent to Treatment

By signing below, I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgement. I understand that I have the right to refuse any medical or surgical treatment which I do not want.

Signature Printed Name Date

Notice of Privacy Practices

Assignment of Insurance

The undersigned hereby assigns to Austin Association of Otolaryngologists all rights, title and interest in any payment due patient and/or undersigned for medical care, services, or supplies described in any health insurance claim form or statement issued by indicated entity. The undersigned understands that this agreement will not eliminate or affect in any way the obligation of the patient and/or undersigned to pay the indicated entity for all services and supplies rendered, including but not limited to, any co-payments or deductibles required by a particular healthcare program or plan.

Release of Medical Information

I hereby authorize the release of any medical record of all results of any testing and other pertinent information acquired during my treatment to the physician as deemed necessary. I agree that a digital image of this authorization shall be considered as effective and valid as the original.

Responsibility of co-payment/deductible, lab and referrals

Based on the particular plan of insurance carried by the patient and/or insured, and such financial responsibilities set forth within their policy shall be made payable during that particular visit to the provider. These include co-payments, deductibles, and co-insurance when deemed appropriate. The patient and/or insured also agrees that it is their responsibility to obtain any referral deemed necessary by their health plan in order to be seen by a provider in this office. Patient also acknowledges that they will be financially responsible for visits that were not authorized by their health plan. It is the responsibility of the patient/insured to be aware of which lab company is their health plan network.

If you need to cancel your appointment, please notify us at least 24 hours in advance of your scheduled appointment. We will assess a $60 fee for each cancellation or no show without the required 24 hour cancellation notice.

Results of tests

It is the expressed policy of this office that no patient shall receive the results of any diagnostic or laboratory testing by means of telephone or written letter unless previously agreed to and documented in the medical record by the provider.

_____ _____

Insured/Patient Signature Date

Medical History

Patient Name _____ **DOB** _____

ALLERGIES? ☐ **No Allergies** **(Please fill out completely)**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ Minimal ☐ partial ☐ significant

Pharmacy Name (Address &/or Phone) _____

Preferred Lab: (circle one or indicate 'other') CPL Quest Other _____

MEDICAL / SURGICAL HISTORY: **HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular: **Yes Year and Hospital**

Coronary Artery Disease ☐ _____

Elevated Cholesterol (hyperlipidemia) ☐ _____

High Blood Pressure (hypertension) ☐ _____

Gastrointestinal:

Hepatitis ☐ _____

Hernia ☐ _____

Gastroesophageal Reflux ☐ _____

Genitourinary:

Prostate enlargement (Benign Prostate Hyperplasia) ☐ _____

Kidney Stones (Nephrolithiasis) ☐ _____

Renal Failure (Acute) ☐ _____

Ear / Nose / Throat: (HEENT)

Cataracts ☐ _____

Glaucoma ☐ _____

Chronic Ear Infections (Otitis Media) ☐ _____

Hearing Loss ☐ _____

Sinus Problems (chronic sinusitis) ☐ _____

Nasal Polyps ☐ _____

Nasal Allergies ☐ _____

Recurrent Tonsillitis ☐ _____

Tinnitus ☐ _____

Vertigo ☐ _____

Hematologic :

Anemia ☐ _____

Immunologic: **Yes Year and Hospital**

Allergies Type: _____ ☐ _____

Food Allergies Type: _____ ☐ _____

Infectious Disease:

Mononucleosis ☐ _____

STD Type: _____ ☐ _____

Metabolic/endocrine:

Diabetes Type: _____ ☐ _____

Thyroid deficiency (hypothyroidism) ☐ _____

Thyroid excess (hyperthyroidism) ☐ _____

Neoplastic:

Cancer Type: _____ ☐ _____

Neurologic:

Migraine ☐ _____

Obstetric:

Pregnancy Date(s): _____ ☐ _____

Psychiatric:

Adjustment Disorder - Anxiety ☐ _____

Major Depression ☐ _____

Pulmonary:

Asthma ☐ _____

COPD ☐ _____

Emphysema ☐ _____

Sleep Apnea ☐ _____

Tuberculosis ☐ _____

Problems with anesthesia _____**Yes** _____**No**

Chief Complaint _____

Patient Name _____ **DOB** _____

List all Medications you are taking including prescription, over-the-counter and herbal:

Medication	Dosage	How often taken

FAMILY HISTORY: **Relationship**

ADD/ADHD ___Yes___No _____
Alcoholism ___Yes___No _____
Allergies ___Yes___No _____
Alzheimer's Disease ___Yes___No _____
Asthma ___Yes___No _____
Blood disease ___Yes___No _____
CAD (Coronary Artery Disease) ___Yes___No _____
CAD-Premature ___Yes___No _____
Cancer Type: _____ _____
CVA (Stroke) ___Yes___No _____
Depression ___Yes___No _____
Developmental delay ___Yes___No _____
Diabetes ___Yes___No _____
Eczema ___Yes___No _____
Autoimmune Disorder Type ___Yes___No _____

Hearing deficiency ___Yes___No _____
Hyperlipidemia ___Yes___No _____
Hypertension ___Yes___No _____
Irritable Bowel Syndrome ___Yes___No _____
Learning disability ___Yes___No _____
Mental illness ___Yes___No _____
Migraines ___Yes___No _____
Obesity ___Yes___No _____
Osteoarthritis ___Yes___No _____
Osteoporosis ___Yes___No _____
PVD ___Yes___No _____
Renal disease ___Yes___No _____
Seizure disorder ___Yes___No _____

Other Family History:

_____

Patient Name _____ **DOB** _____

Tobacco Use? ☐ Yes ☐ No ☐ Former

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ Yes ☐ No ☐ Former

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ Yes ☐ No

Caffeine Consumption? ☐ Yes ☐ No **Type:** _____ **Amount per day?** _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

No Yes
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night sweats
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain

Eye problems

No Yes
- ☐ ☐ Double vision
- ☐ ☐ Glaucoma
- ☐ ☐ Redness

Ear problems

No Yes
- ☐ ☐ Drainage
- ☐ ☐ Hearing loss
- ☐ ☐ Infections
- ☐ ☐ Dizziness
- ☐ ☐ Itchiness
- ☐ ☐ Exposure to Excessive Noise
- ☐ ☐ Ear pain
- ☐ ☐ Ringing /noise in ears

Nose & Sinus problems

No Yes
- ☐ ☐ Congestion
- ☐ ☐ Facial Pain
- ☐ ☐ Mouth Breathing
- ☐ ☐ Nose Bleeds
- ☐ ☐ Sneezing
- ☐ ☐ Runny Nose
- ☐ ☐ Post Nasal Drainage

Mouth & Throat problems

No Yes
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Sleep Apnea
- ☐ ☐ Snoring
- ☐ ☐ Sore Throat
- ☐ ☐ Hoarseness
- ☐ ☐ Sores/Ulcers in Mouth

Heart or circulation problems

No Yes
- ☐ ☐ Heart Murmur
- ☐ ☐ Chest pain
- ☐ ☐ Swelling of Ankles/Edema
- ☐ ☐ Blacking Out
- ☐ ☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems

No Yes
- ☐ ☐ Cough
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing

Musculoskeletal:

No Yes
- ☐ ☐ Leg pain

Stomach problems

No Yes
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn/Reflux
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Brain or Nervous system problems

No Yes
- ☐ ☐ Headache
- ☐ ☐ Seizures
- ☐ ☐ Focal Weakness
- ☐ ☐ Numbness

Glands & Hormone problems

No Yes
- ☐ ☐ Heat Intolerance
- ☐ ☐ Cold Intolerance
- ☐ ☐ Neck Enlargement/Goiter

Blood or Lymph nodes problems

No Yes
- ☐ ☐ Easy Bleeding
- ☐ ☐ Easy Bruising

Allergy problems

No Yes
- ☐ ☐ Food Allergies
- ☐ ☐ Bee Sting Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Urticaria / Hives

Skin

No Yes
- ☐ ☐ Itchy Skin/ Pruritis
- ☐ ☐ Rash
- ☐ ☐ Contact Allergy

Patient Name: _____ **DOB:** _____

Responsible Party Signature: _____ **Date:** _____