

**WHITE ROCK ENT PATIENT INFORMATION SHEET**

Patient's Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle I \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City/ST \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone: (number you wish to be reached at) \_\_\_\_\_ Other # \_\_\_\_\_

May we leave information on your answering machine or voicemail?  Yes  No Preferred Language \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security: \_\_\_\_\_ Sex  M  F

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Emergency Contact: Name, Phone Number, & Relationship:

\_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Who Referred you?  Physician  Relative  Friend  Website  Insurance Co.  Other \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT: ( ) Same as above**

Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle I \_\_\_\_\_

Address: \_\_\_\_\_ City/ST \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

**SUBSCRIBER: (Who is the insurance under?) ( ) Same as above**

Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle I \_\_\_\_\_

Address: \_\_\_\_\_ City/ST \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

**PHARMACY:**

\_\_\_\_\_ Phone number: \_\_\_\_\_

Cross Streets: \_\_\_\_\_

Do you have a power of attorney? If so, please list:

\_\_\_\_\_

\*\* Authorization to discuss protected information: i.e. spouse, parents, children

\*\* Please be advised that any person not listed above will not be given any information related to your care, including billing information. You may make changes to this listing at any time.

# Patient Health History

Name: \_\_\_\_\_

Reason for Visit \_\_\_\_\_

How long have you had this condition?  
\_\_\_\_\_  
\_\_\_\_\_

## 1. MEDICATIONS: ( ) NONE

Please list ANY prescription or over-the-counter/herbal medications currently being taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 2. MEDICATION ALLERGIES: ( ) NONE

Please list ANY medications you are allergic to:

\_\_\_\_\_  
\_\_\_\_\_

## 3. NON MEDICATION ALLERGIES: ( ) NONE

Are you allergic to any of the following?

- Dairy
- Eggs
- Seafood
- Bakers yeast
- Iodine
- Latex
- Contrast agent (dye)

## 4. PAST MEDICAL HISTORY: ( ) NONE

Have you have been diagnosed with any of the following?

- Cancer
- Radiation therapy
- Nasal allergies
- Sleep apnea
- Angina
- Congestive heart failure
- Elevated blood cholesterol
- Heart attack
- Hypertension
- Irregular heart beat requiring treatment
- Asthma
- Chronic obstructive pulmonary disease
- Emphysema
- Tuberculosis
- Hepatitis
- Hernia
- Reflux
- Stomach Ulcer
- Renal failure
- Unspecified type of arthritis
- Stroke
- Depression
- Diabetes (type uncertain)
- Hyperthyroidism
- Hypothyroidism
- Anemia of unknown cause
- Clotting disorder
- AIDS
- HIV infection (a symptomatic)

## 5. PAST SURGICAL HISTORY: ( ) NONE

Problems with anesthesia ( ) check if yes

Please list any past surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 6. IMMUNIZATIONS

**Patients 50+ yrs old:** Have you had a flu shot?

If yes, Month \_\_\_\_\_ Year \_\_\_\_\_

**Patients 65+ yrs old:** Have you had a pneumonia shot?

If yes, Month \_\_\_\_\_ Year \_\_\_\_\_

**Women age 40-69 yrs:** Have you had a mammogram within the past two years?

If yes, Month \_\_\_\_\_ Year \_\_\_\_\_

## 7. FAMILY MEDICAL HISTORY: ( ) NONE

- Problems with anesthesia
- Cancer
- Hearing loss before age 50
- Familial Hypercholesterolemia
- Heart disease
- Hypertension
- Asthma
- Stroke
- Alcoholism
- Diabetes
- Thyroid disease
- Bleeding or blood clotting problems
- Allergies requiring treatment

## 8. SOCIAL HISTORY

- Single
- Married
- Divorced
- Widowed
- Legal Partner

### Current use of tobacco products?

- None
- Never smoker
- Former smoker
- Yes, currently uses tobacco products

### Use of tobacco products in the past that are no longer used?

- None
- Cigarettes
- Pipe tobacco
- Smokeless tobacco
- Cigar

### Current use of alcoholic beverages?

- None
- Yes, currently consumes some alcohol

### Use of alcoholic beverages in the past that are no longer used?

- No
- Yes

### Home living situation?

- Lives alone
- Lives with foster parent(s)
- Lives with spouse
- Lives with spouse and children
- Lives with children
- Lives in assisted living
- Lives with mother and father
- Lives with mother
- Lives in nursing home
- Lives with father
- Lives with legal guardian

**9. REVIEW OF SYSTEM: Please check all that apply:**

- Chills
- Fatigue
- Fever
- Night sweats
- Sleeping problems
  
- Itchy eyes
- Loss of vision
- Watery eye or eyes
  
- Dizziness
- Hearing loss
- Ringing in ears or head noise
  
- Facial pressure sensation
- Nasal congestion
- Mouth-breathing
- Nosebleeds
- Post-nasal drainage
- Runny nose
- Sneezing
  
- Snoring
- Sore throat
- Swallowing difficulties
  
- Blacking out or fainting
- Light headedness or near fainting on standing up
- Palpitations (awareness of heartbeat)
- Shortness of breath only when lying down
- Shortness of breath while sitting or standing
- Swelling including ankles or legs
  
- Cough
- Coughing up blood
- Chest pain or tightness
- Wheezing
  
- Blood in vomit
- Heartburn or indigestion
- Difficulty swallowing liquids
- Difficulty swallowing solids
- Food sticking when swallowing
- Painful swallowing
- Sensation of a lump in throat
- Vomiting
  
- Frequency of urination
  
- Joint pain
- Redness overlying joints
- Joint swelling
  
- Change in alertness
- Change in smell
- Change in taste

- Difficulty remembering
- Difficulty thinking
- Excessive daytime sleepiness
- Headache
- Seizures of unknown type
- Paralysis
- Weakness
  
- Feeling sad more than usual (depressed)
- Trouble sleeping
  
- Increased thirst
- Unwanted or unexpected weight change
  
- Excessive bleeding after injury or minor surgery
- Easy bruising
- Axillary masses
- Groin Masses
- Neck masses
- Masses in areas other than armpit, groin or neck
  
- Seasonal rhinitis

**Height** \_\_\_\_\_

**Weight** \_\_\_\_\_

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health but also render ineffective or possible harmful treatments.

\_\_\_\_\_  
Patient or Guardian signature      Date



White Rock ENT  
1130 Beachview St., Suite 240  
Dallas, TX 75218

## FINANCIAL POLICY

Co-Pays, Coinsurance, and Deductibles are due at the time of service. We accept cash, VISA, MasterCard, Discover, and American Express.

**REFERRALS:** If you have an HMO, or similar plan, you will need a referral from your primary care physician to see our specialists. If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you will be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.

**INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a specialist, there are diagnostic procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures/surgeries. The possible procedures which often are performed in this practice during your visit include, but are not limited to:

Nasal Hemorrhage Control	Tympanostomy/Myringotomy
Nasal Endoscopy with/without debridement	Audio-Comprehensive
Laryngoscopy	Otoacoustic Emissions
Cerumen (ear wax) Removal	Binocular Microscopy
Foreign Body Removal	Nasopharyngoscopy with endoscope

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay, such as your deductible and/or coinsurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives and processes the claim. Therefore, any quote for services will be considered an estimate and any payment will be considered a partial-payment until the insurance company has processed your claim. Your insurance is a contract between you and your insurance carrier; payment is ultimately your responsibility. We here at White Rock ENT feel that it is very important for you to know and understand your coverage.

**FORMS FEE:** Any forms (for example, FMLA, Short-term disability, other extended leave of absences, etc.) which require our physicians to complete must be given to our office staff in a timely manner and will require a \$25.00 fee before being completed. Please allow up to 10 business days for completion.

**NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we request a courtesy call at least 24 hours in advance if you are unable to keep your appointment to allow other patients to be seen. A \$25.00 fee may apply if such notice is not received. Multiple missed appointments may result in our request for you to find another specialist.

**MEDICAL/BILLING RECORDS FEE:** Any request for medical or billing records must be accompanied by an authorization for release of information (obtainable from the front desk). We will make every effort to provide these copies within 10 business days, so please make your request well in advance of other physician appointments. There are fees for the release of records and if records are to be mailed, standard postage rates will be charged to the patient's account.

**RETURNED CHECK FEE:** There is a \$25.00 fee for checks returned for any reason. White Rock ENT does report all bad checks to the Justice of the Peace.

**COLLECTION AGENCY:** Please be aware that White Rock ENT reports unpaid bills to a collection agency. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account. Any patient sent to collections forfeits any future appointments unless the balance is paid in full.

**SURGERY DEPOSIT:** If surgery is recommended, you may be required to pay a portion of your deductible and/or coinsurance prior to the date of surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim.

**ASSIGNMENT OF BENEFITS:** I request that payment of insurance benefits, be made on my behalf to White Rock ENT, or Dwight A. Lee, M.D. or Jennifer A. Jordan, M.D., for any services provided to me. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable by my insurance carrier. A copy of this authorization will be sent to my insurance carrier if requested. The original authorization will be kept on file at White Rock ENT.

**FINANCIAL RESPONSIBILITY STATEMENT:** I have read this notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these procedures will be billed to my insurance, if any. I understand there are other procedures which may be performed as part of my diagnosis or treatment that may not be listed above. I will be responsible for any amount not covered by an insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify White Rock ENT of any changes in my insurance coverage. I understand by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

By signing this document, I also acknowledge that I have received a copy of White Rock ENT's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of privacy rights.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Relationship to patient, if different \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

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