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.

White Rock ENT 1130 Beachview Street, Suite 240 Dallas, TX 75218 214-324-0418 / 214-324-0693 (fax)

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