ADVANCED ENT AND ALLERGY
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Office #: (832) 604-3636 Fax #: (281) 469-8932

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name: *(Last)* _____ *(First)* _____ *(MI)* _____

Preferred Full Name *(if different from above)*: _____ Sex *(Circle one)*: M / F

Date of Birth: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Work / Home #: _____

E-mail Address: _____

Marital Status *(Circle one)*: Single Partnered Married Separated Divorced Widowed

Occupation *(Circle one)*: Retired Disabled Working Current Occupation *(if working)*: _____

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Trans Female to Male
- ☐ Trans Male to Female
- ☐ Genderqueer
- ☐ Choose not to disclose
- ☐ Additional not listed:

_____
_____

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Hispanic
- ☐ Choose not to disclose
- ☐ Other not listed:

_____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Choose not to disclose

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other not listed:

_____

PCP Name: _____ PCP Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: *(Last)* _____ *(First)* _____

Phone #: _____ Do you have a living will? *(Circle one)* Yes No

Relationship to patient: _____ Is emergency contact the patient's guardian? Yes No

Full Address *(If different from patient's)*: _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION *(If not self)* *(Information used for patient balance statement)*

Responsible Party Name: *(Last)* _____ *(First)* _____

Date of Birth: _____ Sex *(Circle one)*: M / F Social Security #: _____

Full Address *(If different from patient's)*: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check in.

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient/Guardian/Representative: _____ Date: _____

Printed Name of Patient/Guardian/Representative: _____ Relation to patient: _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATION

Financial Agreement

- I acknowledge that as a courtesy, ***Advanced Ear, Nose, Throat, & Allergy (Advanced ENT & Allergy)*** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any copayment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection

I acknowledge ***Advanced ENT & Allergy*** may use the services of a third-party business associate or affiliated entity as an extended business office (EBO Servicer), for medical account billing and servicing.

Assignment of Benefits

I hereby assign to ***Advanced ENT & Allergy*** any insurance or other third-party benefits available for healthcare services provided to me. I understand ***Advanced ENT & Allergy*** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to ***Advanced ENT & Allergy***, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit

I certify that any information I provide, if any, in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to ***Advanced ENT & Allergy*** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications

I agree that, in order for ***Advanced ENT & Allergy*** or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that ***Advanced ENT & Allergy*** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided, or at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Signature of Patient/Guardian/Representative: _____ Date: _____

Printed Name of Patient/Guardian/Representative: _____ Relation to patient: _____

HEALTH HISTORY QUESTIONNAIRE

CURRENT MEDICATIONS

Enter your medication(s) below, include over-the-counter medications, vitamins, supplements, and ***aspirin***, or attach your medication list.

NAME	DOSE / STRENGTH	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

Have you ever had a problem / reaction with anesthesia? *(Circle one)* Yes No

If yes, please explain:

Are you allergic to any medications? *(Circle one)* Yes No *If yes*, please list allergy and reaction below.

ALLERGY / MEDICATION	REACTION

PERSONAL SAFETY

Do you live alone? *(Circle one)* Yes No

Do you use a cane? *(Circle one)* Yes No

Do you have frequent falls? *(Circle one)* Yes No

Do you use a wheelchair? *(Circle one)* Yes No

HEALTH HISTORY QUESTIONNAIRE

PERSONAL HEALTH / MEDICAL HISTORY

PAST / CURRENT ILLNESS / INJURY HISTORY (ex: diabetes, high blood pressure, etc.)**:**

YEAR	DESCRIPTION

PAST SURGICAL HISTORY:

YEAR	DESCRIPTION	LOCATION

OTHER HOSPITALIZATIONS:

YEAR	DESCRIPTION	LOCATION

FAMILY HEALTH HISTORY

	AGE	HEALTH PROBLEMS	AGE AT DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
SON(S)			
DAUGHTER(S)			

	AGE	HEALTH PROBLEMS	AGE AT DEATH
PATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL GRANDMOTHER			

HEALTH HISTORY QUESTIONNAIRE

HEALTH HABITS / SOCIAL HISTORY

ALCOHOL Do you drink alcohol? *(Circle one)* Yes No

If yes, how many drinks a week? _____ What type of alcohol? _____

TOBACCO Do you use tobacco? *(Circle one)* Yes Never No, I quit year _____

If yes, check all that apply:

- ☐ Cigarettes, _____ times a day
- ☐ Pipe, _____ times a day
- ☐ Chew, _____ times a day
- ☐ Cigars, _____ times a day

PLEASE CIRCLE ALL THAT APPLY TO YOUR HEALTH CARE PAST OR PRESENT

CONSTITUTIONAL
- Weight Gain
- Weight Loss
- Night Sweats
- Insomnia
- Chills / Fever

CARDIAC AND VASCULAR
- High Blood pressure
- Rheumatic Fever
- Heart Murmur
- Carotid Disease
- Bypass Surgery
- Syncope / Fainting
- Swelling in feet
- Chest Pain or Angina
- Heart Attack
- Palpitations
- Pacemaker
- Defibrillator
- Atrial Fibrillation

NEUROLOGICAL
- Numbness
- Weakness
- Stroke
- Memory Loss
- Headaches / Migraines
- Balance problems
- Blackouts
- Inability to concentrate

MUSCULOSKELETAL
- Leg / Arm Pain
- Leg / Arm Weakness
- Osteoarthritis
- Rheumatoid Arthritis

RESPIRATORY
- Shortness of Breath
- Asthma / Wheezing
- Sleep Apnea
- Snoring
- Trouble breathing at night
- Coughing up blood
- COPD
- TB / Tuberculosis
- Pneumonia

EYES
- Double Vision
- Visual Loss or Changes

EAR, NOSE, THROAT, & MOUTH
- Hearing Loss
- Noise / Ringing in Ears
- Drainage from Ears
- Nasal Congestion
- Nasal Drainage
- Inability to Smell
- Sore Throat
- Trouble Swallowing
- Hoarseness
- Vertigo / Dizziness

ENDOCRINE
- Diabetes
- Thyroid Disease
- Other: _____

PSYCHIATRIC
- Depression
- Anxiety
- Other: _____

ALLERGIC / IMMUNOLOGIC
- Sneezing
- Itching Eyes
- Itchy Throat
- Skin Rash
- HIV

GASTROINTESTINAL
- Abdominal Pain
- Blood in Stool
- Black Tarry Stool
- Bowel Incontinence
- Hepatitis
- Acid Reflux / Heartburn
- Jaundice
- Liver Trouble
- Ulcer
- Nausea / Vomiting

GENITOURINARY
- Urinary Incontinence
- Bladder Trouble
- Blood in Urine
- Kidney Disease
- Prostate Disease
- Sexual Dysfunction

HEMATOLOGICAL
- Bleeding Disorder
- Easy Bleeding
- Other: _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Notice of Privacy Practice / Clinics

I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

If I want to designate a family member or other individual(s) with whom the provider may discuss my medical condition(s), I will list the family members and/or others below.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and/or others listed below.

FULL NAME	RELATIONSHIP	CONTACT NUMBER

*Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

****Note:** This location uses an Electronic Health Record that will update *all your demographics and consents* to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Release of Information

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- **I do want** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

FULL NAME	RELATIONSHIP TO PATIENT

- **I do not want** _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of Patient/Guardian/Representative: _____ Date: _____

Printed Name of Patient/Guardian/Representative: _____ Relation to patient: _____

APPOINTMENT TIME / CANCELLATION POLICY

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have an appointment time / cancellation policy that allows us to schedule appointments for all patients. When arriving early or late, it interferes with the time reserved for another patient and when missed, that time cannot be used to treat another patient. Our policy is as follows:

If you arrive earlier than your appointment time, we require that you patiently wait in our waiting room until your appointment time to be seen by the doctor. This allows our practice to effectively function and allows each patient their fully allocated time slot to receive comprehensive care.

In the event that you need to reschedule your appointment, we require that you give our office a **24-hour notice**. This allows for other patients to be scheduled into that time slot. If you miss an appointment without contacting our office within the required time, it will be considered a missed appointment. **A cancellation fee of $25.00 will be charged to you.** This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment for this fee.

Additionally, if a patient is **more than 15 minutes late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$25.00 cancellation fee will be charged.**

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

My signature below indicates that I have read and understood the appointment time / cancellation policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Guardian/Representative: _____

Printed Name of Patient/Guardian/Representative: _____

Date: _____