# WELCOME TO OUR PRACTICE
## New Patient Questionnaire
*Adults 18 and older*

Today's date: ______________________ MR#: __________

## PATIENT INFO

Last name ______________ First Name ______________ MI ______ Sex: ❑ M ❑ F

Age ______ Birth Date ______________ Social Security # ______________ Driver's Lic # ______________

Home Address ______________________________

City ______________ State ______________ Zip ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

E-mail address to reach you: ______________________

May we share your e-mail address with the hospital or surgery center if you schedule surgery with one of our physicians? ❑ Yes ❑ No

Are you employed? Yes ______ No ______ Retired ______ Student ______

If yes, name of Employer ______________________________

Occupation ______________________________

Employer Address ______________________ Phone ______________

Are you married? ❑ Yes ❑ No Name of spouse/partner ______________ Phone ______________

Spouse/Partner Employer's name & address ______________________________

The Pharmacy you normally use ______________________ Phone ______________

Name of nearest relative not living with you ______________________ Relationship ______________

Address ______________________ Phone ______________

## PRIMARY INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ PPO ❑ HMO ❑ POS ❑ Private Pay

Insurance Company name & address ______________________________

Policy holder's name ______________________ Birth date ______________

Relationship to patient ______________________ Social Security # ______________

Phone # ______________ Identification # ______________ Group # ______________

## SECONDARY INSURANCE INFORMATION

Insurance Company name & address ______________________________

Policy holder's name ______________________ Birth date ______________

Relationship to patient ______________________ Social Security # ______________

Phone # ______________ Identification # ______________ Group # ______________

**REFERRED BY:** ❑ Friend ❑ Physician ❑ www.austinentassociates.com ❑ Internet

❑ Other ______________ Have you or any of your family been previous patients? ❑ Yes ❑ No

If yes, name of patient ______________________ When? ______________

Referring Physician ______________________ Phone ______________

Primary Care Physician ______________________ Phone ______________

Dentist ______________________ Phone ______________

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*Adults 18 and older*

Patient: ______________ DOB: ______________ MR#: ______________ Date: ______________

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? ______________

What medications are you currently taking? Include any blood thinning over the counter agents such as aspirin, Motrin, Orudis, Aleve, Relafen, Lodine, ibuprofen, or naproxen. If you have a list, please let us make a copy of your list.

What medication allergies do you have? Please include the type of reaction you experienced:

Please list medical problems that are currently being treated by another physician (i.e. Hypertension, Heart Attack, Emphysema, etc.):

Please list any surgeries you have had in the past and the approximate dates:

Have you or any family member had any adverse reactions to general anesthesia? If yes, please explain: ______________

Have you received radiation in the past? Yes _____ No _____

Do you smoke? Yes _____ No _____ If yes, how many packs a day? _____ For how many years? _____

Do you chew tobacco? Yes _____ No _____ If yes, for how many years? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If yes, how many drinks per day/week? _____

Do you use any other "recreational drugs"? Yes _____ No _____

Please list any other information you think your physician should know about your health:

 Physician Initials _____ Date _____

# WELCOME TO OUR PRACTICE

## New Patient Questionnaire

*Adults 18 and older*

**The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.**

| | Problem | Patient | Family | Please explain |
|---|---|---|---|---|
| General | Fever/chills | | | |
| | Fatigue | | | |
| | Weight change | | | |
| Eye | Change in vision | | | |
| | Glasses | | | |
| | Cataracts or glaucoma | | | |
| Ear, Nose, & Throat | Nosebleeds | | | |
| | Sore throat or tonsillitis | | | |
| | Hoarseness | | | |
| | Swallowing problems | | | |
| | Hearing problems | | | |
| | Dizziness or Vertigo | | | |
| | Sinus or nose problems | | | |
| | Tinnitus (ears ringing) | | | |
| Allergy | Seasonal Hayfever | | | |
| | Food reactions | | | |
| | Allergy shots | | | |
| | Latex reactions | | | |
| Lung | Asthma | | | |
| | Chronic cough | | | |
| | Bronchitis or pneumonia | | | |
| Heart | Chest pain or palpitations | | | |
| | Congestive heart failure | | | |
| | Heart disease or surgery | | | |
| | High blood pressure | | | |
| | Coronary artery disease | | | |
| | High cholesterol/triglycerides | | | |
| GI | Acid reflux / heartburn | | | |
| | Abdominal pain | | | |
| | Peptic ulcer disease | | | |
| | Hepatitis / jaundice | | | |
| GU | Prostate problems | | | |
| | GYN problems | | | |
| MS | Arthritis problems | | | |
| | Back or neck problems | | | |
| | Muscle weakness | | | |
| | Gout | | | |
| Skin | Hives or rashes | | | |
| | Eczema | | | |
| | Breast disease | | | |
| Neurologic | Stroke | | | |
| | Seizures | | | |
| | Headaches or Migraines | | | |
| | Neurologic problems | | | |
| Endocrine | Diabetes | | | |
| | Thyroid problems | | | |
| | Pituitary or adrenal problems | | | |
| | Perimenopausal symptoms | | | |
| Psyche | Depression | | | |
| | Anxiety | | | |
| Immune | Bleeding disorders | | | |
| | Anemia problems | | | |
| | Enlarged lymph nodes | | | |
| | HIV / AIDS | | | |



Physician Initials ______ Date ________

## FINANCIAL POLICY

Co-Payments and payment for services not covered by your insurance will be due at your visit. For your convenience, we accept cash, check, debit or credit card (MasterCard, Visa, Discover, and American Express).

**Private pay patients are expected to pay in full at the time of the service.** Payment for a limited new patient visit will be collected before you are called back to see the physician. An additional fees for services will be collected at checkout.

We do not accept insurance forms in lieu of payment but will provide you with a receipt that will assist you in collecting payment from your insurance carrier. We are providers for several PPO and HMO insurance plans. If we are providers under your plan, we will file your claim for you if you provide proof of insurance (insurance card). **You are responsible for obtaining necessary referrals prior to your visits or you will be asked to reschedule your appointment.** All health plans are not the same and do not cover the same services. In the event your health plan determines that a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

**We will expect payment from the adult accompanying a minor for all services rendered to minor patients.**

We do not file third party insurance for your motor vehicle accidents or liability claims. We do not wait for claims to be settled in or out of court. We expect payment from you until a settlement is made.

**Medicare:** We will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your deductible if not met at the time, as well as your 20 percent.

Please sign here that you have read this office policy and agree to it. If there is a problem, please speak to the cashier before seeing the doctor.

x ______________________________ ______________________________

Patient or Parent/Guardian Signature Date

## RELEASE INFORMATION

I hereby authorize Austin ENT Associates to furnish medical information concerning my present illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Austin ENT Associates.

x ______________________________ ______________________________

Patient or Parent/Guardian Signature Date

## ASSIGNMENT OF BENEFITS

I request payment of the surgical and/or medical benefits, otherwise payable to me, directly to Austin ENT Associates for services provided by them. I understand that I am financially responsible to Austin ENT Associates for charges not covered by this Assignment of Benefits.

x ______________________________ ______________________________

Patient or Parent/Guardian Signature Date

## CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by Drs. Scholl, Austin, Zapalac and/or Ratcliff.

x ______________________________ ______________________________

Patient or Parent/Guardian Signature Date