



WELCOME TO OUR PRACTICE
New Patient Questionnaire
Children 17 or younger

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

PARENT/GUARDIAN INFO: Parent/Guardian name(s)
Home Phone Cell Phone Work Phone
Name of person child currently lives with Relationship
Are you employed? Yes No Retired If yes, name of Employer
Occupation
Employer Address Phone
If married, Spouse/Partner's name Spouse/Partner's work #
Spouse/Partner Employer's name & address
Best e-mail 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
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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Patient: _____ DOB: _____ Date: _____

Your child's medication, medication allergies, and past health problems are an important part of their diagnosis and treatment plan. Please try to answer all questions fully.

What kind of problem is your child having? _____

What medications is your child currently taking? (If you have a list, please let us make a copy of your list.)

What medication or contact allergies does your child have? Please explain the type of reactions your child has experienced.

Please list any medical problems that your child has:

Please list any surgeries your child has had in the past and the approximate dates:

Has your child or any family member had any adverse reactions to general anesthesia? If so, please explain.

Does anyone smoke in the home? Yes _____ No _____

Does your child go to daycare? Yes _____ No _____

How many other children are there in your household? _____ What are their ages? _____

Birth History:

Was your child born at term? Yes _____ No _____

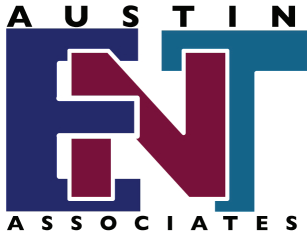
Please list any other information you think your physician should know about your child's health:



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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			



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