8230 Walnut Hill Lane
Building 3, Suite 420
Dallas, Texas 75231
(214) 265-0800

SouthWest ENT
ADULT & PEDIATRIC
EAR, NOSE & THROAT SPECIALISTS

6300 West Parker Road
Building 2, Suite 221
Plano, Texas 75093
(972) 378-3708

Patient name: (Last):_____ (First):_____ (Initial):_____
Street Address: _____ City:_____ State:_____ Zip: _____
Sex: _____ Age: _____ Date of Birth: ___/___/_____ SSN: _____ Race: _____ Ethnicity: _____
Home Phone #: (____) _____-_____Mobile Phone #: (____) _____-_____Work Phone #: (____) _____-_____ Ext. _____
Email Address: _____ Primary Language: _____ Is a Translator Needed? _____
Referring Physician: _____ Primary Care Physician: _____

INSURANCE INFORMATION (**This section MUST BE FILLED OUT. Provide the information for the insured/person that provides the coverage**)

Primary Insurance Carrier: _____Policyholder Employer: _____
ID #: _____ Group #: _____
Policyholder Name: _____ Policy Holder D.O.B.: _____
Policyholder SSN: _____ Relationship to Patient: _____

Secondary Insurance Carrier: _____Policyholder Employer: _____
ID #: _____ Group #: _____
Policyholder Name: _____ Policy Holder D.O.B.: _____
Policyholder SSN: _____ Relationship to Patient: _____

Pharmacy Information (**Please provide us the information of the pharmacy you would like all prescriptions to be sent to**)

Pharmacy Name: _____ Phone #: (____) ____-_____ Fax #: (____) ____-_____

Street Address: _____ City:_____ State:_____ Zip: _____

Payment is expected at the time of the service. If we are a participating provider in your insurance plan, you must present a valid insurance card at the time of service or be responsible for payment in full. If a current ID card is not presented prior to the visit, the patient will not be eligible for any benefits of the plan.

Signature of Patient or Parent/Guardian: _____ Date: _____

PLEASE COMPLETE IF PATIENT IS A CHILD (UNDER 18 YEARS OLD)

Give information for the PARENT/LEGAL GUARDIAN that is accompanying the child to this visit

Name: _____ Relationship to Patient: _____
Street Address: _____ City:_____ State:_____ Zip: _____
Home Phone #: (____) ____-_____Mobile Phone #: (____) ____-_____Work Phone #: (____) ____-_____Ext. _____

I acknowledge that payment is due at the time of service, unless other arrangements have been made. I agree that parent/guardians are responsible for fees and services rendered for treatment of a minor/child. I understand that SouthWest ENT Associates will not get involved in matters involving third party personal billing whether result of custody, court order, or personal circumstances. The parent/guardian accompanying the child to the visit is responsible for any payment due at the time services are rendered. I accept full financial responsibility for all charges not covered or paid by insurance.

Signature of Parent/Guardian (as identified above): _____ Date: _____
SSN: _____ D.O.B.: _____

8230 Walnut Hill Lane
Building 3, Suite 420
Dallas, Texas 75231
(214) 265-0800

SouthWest ENT
ADULT & PEDIATRIC
EAR, NOSE & THROAT SPECIALISTS

6300 West Parker Road
Building 2, Suite 221
Plano, Texas 75093
(972) 378-3708

Name: _____ Birthdate: _____ /_____ /_____ Date: _____ /_____ /_____

PATIENT HISTORY

Drug Allergies: **No Known Drug Allergies** **Yes** _____

Current Medication(s): _____

Do you currently have or frequently experience . . .

_____ Alcoholism	_____ Cancer	_____ Heart Failure	_____ Mental Illness
_____ Anemia	_____ Diabetes	_____ Hepatitis	_____ Stroke
_____ Arthritis	_____ Emphysema	_____ High Blood Pressure	_____ Thyroid Problem
_____ Asthma	_____ Epilepsy/Seizures	_____ HIV/AIDS	_____ Tuberculosis
_____ Birth Defects	_____ Glaucoma	_____ Kidney Disease	_____ Venereal Disease
_____ Bladder Disease	_____ Headaches	_____ Liver Problem	_____ Weight Loss/Gain
_____ Bleeding Disorder	_____ Heart Attack	_____ Lung Problem	_____ Other: _____

In the last Six Months:

Number of Nasal/Sinus Infections: _____
Number of Ear Infections: _____
Number of Tonsillitis/Strep Throat: _____

Antibiotics Taken in the Last Six Months:

_____ Amoxicillin	_____ Cedax	_____ Omnicef	_____ Other: _____
_____ Augmentin	_____ Ceftin	_____ Rocephin	_____
_____ Biaxin	_____ Cefzil	_____ Suprax	_____
_____ Ceclor	_____ Lorabid	_____ Zithromax	_____

PAST SURGICAL HISTORY

_____ Adenoidectomy
_____ Ear Tubes
_____ Tonsillectomy
_____ Other: _____
_____ Other: _____
_____ Other: _____

FAMILY HISTORY

Has anyone in your family had . . .

_____ Alcoholism	_____ Cancer	_____ Heart Failure	_____ Thyroid Problem
_____ Anemia	_____ Diabetes	_____ High Blood Pressure	_____ Tuberculosis
_____ Arthritis	_____ Emphysema	_____ Kidney Disease	_____ Other: _____
_____ Asthma	_____ Epilepsy/Seizures	_____ Liver Problem	_____ Other: _____
_____ Birth Defects	_____ Glaucoma	_____ Lung Problem	_____ Other: _____
_____ Bladder Disease	_____ Headaches	_____ Mental Illness	
_____ Bleeding Disorder	_____ Heart Attack	_____ Stroke	

SOCIAL HISTORY

Do You . . .	**How Often:**
_____ Exercise	_____
_____ Use Alcohol	_____ Beer/Wine/Liquor
_____ Use Tobacco	_____ Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco
_____ Use Drugs	_____ Marijuana/Heroin/Cocaine/LSD/Other

PLEASE COMPLETE THE BACKSIDE

Name: _____ Birthdate: _____ /_____ /_____ Date: _____ /_____ /_____

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: _____ ***Healthy*** _____ ***Not Healthy*** _____ ***Other:*** _____

Do you currently have or frequently experience: (Please check ALL that apply)

Eyes	_____ None	_____ Blurred Vision _____ Other: _____	_____ Painful Eyes	_____ Irritation from Light
Ears, Nose, Throat & Mouth	_____ None	_____ Itching _____ Rhinitis _____ Bruxism (teeth grind) _____ Pressure in Ear	_____ Nose Blocked _____ Sores in Mouth _____ Difficulty Swallowing _____ Other: _____	_____ Post Nasal Drip _____ Teeth Hurt _____ Painful Swallowing _____ Hearing Loss
Cardiovascular (Heart)	_____ None	_____ Palpitations/ Fluttering of Heart	_____ Pain in Chest _____ Other: _____	_____ Shortness of Breath while Exercising
Respiratory (Lungs)	_____ None	_____ Wheezing _____ Other: _____	_____ Shortness of Breath while Sitting	_____ Cough
Gastrointestinal (Stomach)	_____ None	_____ Constipation _____ Indigestion	_____ Diarrhea _____ Other: _____	_____ Pain
Genitourinary	_____ None	_____ Hesitation when urinating	_____ Urination at night _____ Other: _____	_____ Pain when urinating
Musculoskeletal	_____ None	_____ Soreness	_____ Weakness _____ Other: _____	_____ Cramping
Integumentary (Skin)	_____ None	_____ Itchy Skin _____ Dry Skin	_____ Lesions on Skin _____ Other: _____	_____ Bleeding
Neurological (Nerves)	_____ None	_____ Twitch _____ Abnormal Movements	_____ Ringing in Ears _____ Other: _____	_____ Dizziness/Vertigo
Psychiatric	_____ None	_____ Mood Swings _____ Depression	_____ Situational Stress _____ Anxiety	_____ Change _____ Other: _____
Endocrine	_____ None	_____ Hot Flashes _____ Cold	_____ Hair Loss/Growth _____ Other: _____	_____ Heat
Hematologic/ Lymph Nodes	_____ None	_____ Bleeding Easily	_____ Night sweats	_____ Other: _____
Allergic/ Immunologic	_____ None	_____ Sneezing	_____ Eye Irritation _____ Other: _____	_____ Reactions

Patient Comments:

Patient Registration Consent and Disclosures

Patient Name: _____ Date of Birth: _____ / _____ / _____

Consent to Treatment

I certify that I am the patient or the parent/legal guardian of the patient, and I consent to treatment necessary for the care of the patient indicated on this form.

Payment Policy

I understand and acknowledge the following:

- I am responsible for payment of professional services at the time they are rendered.
- I am responsible for any amount not covered by insurance including, with limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned.
- Verification of benefits given to SouthWest ENT Associates by my insurance company is not a guarantee of payment.
- SouthWest ENT Associates files claims for Medicare assignment and any of the managed Care Plans with which they participate.
- Claims will not be filed with insurance carriers SouthWest ENT Associates does not participate with.
- Failure to provide the correct and accurate information regarding insurance in order to file claims accurately and timely could result in claim denial therefore may result in patient responsibility.
- If I choose to pay by check, and it is returned, a processing fee of $50 will be assessed.

Assignment of Benefits

I assign to SouthWest ENT Associates all payments for medical service rendered to my dependent(s) or myself for services filed to insurance on my behalf.

Medicare Patient Authorization

I authorize any holder of medical information about me, to release to the Social Security Administration and Health Care Financing Administration (HCFA) or its intermediaries or carriers any information needed for this or any other related Medicare claim. I permit a copy of this authorization to be used in place to the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I also authorize the same of information to any Medicare supplemental insurance (i.e. Medigap) and further request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Authorization for Release of Medical Information

I hereby authorize SouthWest ENT Associates to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

Authorization to Mail, Call, or E-Mail

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize SouthWest ENT Associates designated provider(s), or those under his/her supervision and/or representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders and account balance information. I understand that have the right to rescind this authorization at any time by notifying SouthWest ENT Associates to that effect in writing.

Disclosure Regarding Surgery Centers

I understand that Evan Bates, M.D. is affiliated as owner with, and has financial interest in the following surgery centers or hospitals: Presbyterian Plano Center for Diagnostics and Surgery, Cook Children's Pediatric Surgery Center, and Texas Institute for Surgery at Presbyterian Hospital of Dallas. As a patient, I have the option to use an alternative health care facility and SouthWest ENT Associates will not treat me differently if I choose to use an alternate facility.

I may revoke consent for any and all of the above items at any time by notifying SouthWest ENT Associates in writing.

_____ _____

Patient or Parent/Legal Guardian Signature **Date**

Southwest ENT Associates

PATIENT CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, Southwest ENT Associates originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and healthcare operations in assessing quality of healthcare.

Southwest ENT Associates *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Southwest ENT Associates reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices,* the revised Notice will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Southwest ENT Associates is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Southwest ENT Associates has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

_____ I request the following restrictions on the use and/or disclosure of my personal health information:

_____

I further understand any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as other provided by law or stated below:

I agree to allow Southwest ENT Associates, P.A. to disclose my Private health Information (including date/time of appointments) to:

_____	**_____**
Name of Individual	**Relationship (e.g., Daughter)**
_____	**_____**
Name of Individual	**Relationship (e.g., Daughter)**

_____ Myself only, no other family member or friend, or Individual

I have been provided and have reviewed Southwest ENT Associates *Notice of Privacy Practices* dated October 4, 2016.

_____

Please Print Patient Name

_____	**_____**
Signature of Patient/Legal Representative Date	**Signature of Witness Date**
_____	**_____**
Print Name of Patient/Legal Representative	**Print name of Witness**