PATIENT INFORMATION

PLEASE PRESENT INSURANCE CARD/S WITH THIS FORM

Patient's Name (FIRST) ____________________ M.I. _______ (LAST)______________________

Mailing Address ____

City ______________________________________ State ___________ Zip ___________________

Email Address _______________________________

S.S. #______________________________

DOB ______/_____/_____

Primary Phone _____________________ (Home/Business/Cell)

Secondary Phone ___________________ (Home/Business/Cell)

Preferred Method of Contact for Appointment Reminders - Text Message//Phone/Other

Gender - Male/Female

Race – White/Black or African American/American Indian/Asian/Native Hawaiian/Hispanic/Other

Marital Status: Married/Single/Divorced/Widowed

Ethnicity - Hispanic or Latino   Not Hispanic or Latino   Declined to Provide

Employment __________________________________ Employer Phone No.________________

Emergency Contact ___________________________ Relationship ________________________

Emergency Phone No. ________________________

SPOUSE NAME ___________________________ SPOUSE D.O.B________________________

Referring Physician _______________________________

How did you hear about us? Billboard Sign Friend Internet Newspaper Referring Physician Bluffs and Bayous Magazine Radio Ad Telephone Book

Payment Policy:

- **Surgery Fee –** A deposit of $250.00 must be paid **prior** to patient's surgery date.
- **Excision Fee** – A deposit of $150.00 must be paid at time of service.
- **Office Fee/Co-Pay** – Insurance Co-Pays are due at time of service and payment in full is required for all other services.

Assignment of Benefits • Financial Agreement • Authorization to Release Information

I hereby give lifetime authorization to any physician, nurse practitioner, hospital, or medical care facility to provide information to Brookhaven ENT Allergy & Facial Surgery for the furtherance of my health care services.

I hereby agree to be responsible for the payment of the patient's account. If not paid when due, I will be responsible for any collection fees and/or attorney fees to collect this account. Our office will file primary and secondary insurance as a courtesy. However, we do not file secondary insurance for allergy injections.

I request that payment of authorized insurance benefits be made either to me or on my behalf to BROOKHAVEN EAR, NOSE & THROAT CLINIC for any services furnished me by that physician/provider. I authorize any holder of medical information about me to release to BROOKHAVEN EAR, NOSE & THROAT CLINIC and its agents any information needed to determine these benefits or the benefits for related services.

______________________________________ ____________________________

Signature of Patient/Guardian Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (TPO)

Signing this consent allows our office to use and disclose your Protected Health Information for Treatment, Payment, or Health Care Operations (TPO). Signing this consent also establishes a written acknowledgement that the **Notice of Privacy Practices for Protected Health Information** has been presented to and/or received by you.

____

Signature of Patient or Parent or Legal Representative

____

Name of Patient (Please Print)

____

Date

Please list any other person(s) whom we may discuss health information and/or payments regarding your account with Brookhaven Ear, Nose & Throat Clinic.

___________________________________ ______________________________________

Phone No. __________________________ **Phone No.** _____________________________

May we leave a message on your answering machine or cell phone voice mail? _____Yes _______No

Ryan C. Case, MD
Otolaryngology/Head and Neck Surgery
Board Eligible
Carol A. Buckels, CFNP
Certified Nurse Practitioner
Lesleye L. Smith, CCC-A
Audiologist

Diseases of the Ears, Nose and Throat—Allergies
Head and Neck Surgery—Facial and Plastic Reconstructive Surgery
Specializing in the Diagnosis and Treatment of Nasal and Sinus Problems

Name____ Date of Birth________________________

Drug Allergies ____ Pregnant/Nursing? Y/N

Reason For Visit____________________________________Referring MD________________________

Does your child have any medical problems other than the reason for the visit today?
___Heart Disease ___Seizures ___Asthma ___Birth Defects___Learning Disability ____ Eczema
___Bleeding Disorders ____Premature Birth___Speech/Language Delay

If others please list:____

Has your child been hospitalized? Y/N Please explain when and why.

____

Does your child have trouble with nasal or eye allergies or asthma? Y/N
Has your child ever been allergy tested? Y/N, If so, when?_________________________________

Does your child get frequent?:
Sinus infections? Y/N How many in past year?____________________________
Ear infections? Y/N How many in past year?____________________________
Tonsil/ throat infections? Y/N How many in past year?____________________________

Does your child snore nightly? Y/N

Do you have concerns about your child's hearing? Y/N

What Surgery has your child had?
___Ear Tubes___Adeniodectomy___Tonsillectomy___Sinus Surgery
Other Surgery:____

Do any diseases run in your child's family? (Circle) Allergies, Hearing Loss, Thyroid. If others please list:
____

Please circle all that apply to your child:
In Daycare In School Grade____ Was/Is Breastfeed Exposed to 2nd Hand Smoke

How did you find out about us? (Circle One) Web site, Facebook Page, Newspaper, Billboard, Radio, TV, Bluffs and Bayous, Referring Doctor, Friend.

Do you have any questions about the cosmetic skin care services we offer? Y/N

Name:____________________________________

Medication History

Allergies to medications/other:

____

____

Current Medications:

Name:	**Dosage:**	**Frequency:**
____________________	____________________	____________________
____________________	____________________	____________________
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Pharmacy:

1st Choice:____________________________________

2nd Choice:____________________________________