Patient Information

Name (Last)_________________(First, Middle Initial)______________________DOB____/____/____

Social Security #______________________________Marital Status: S M D W Sex: M F

Mailing Address______________________________(City)____________(State)______(Zip) ________

Phone (Home)_________________________________(Cell) _________________________________

Work Phone:___________________________**Email Address:** ________________________________

Employer**:** ____

Race: American Indian, Asian, Native Hawaiian, Black/African American, White, Hispanic, Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Language**: English Spanish Indian Other

Parent/Responsible Party Information (if patient is under 18)

Name (Last)__________________(First, Middle Initial)____________________DOB____/____/_____

Relationship to Patient: ____

Social Security #______________________________ Marital Status: S M D W Sex: M F

Mailing Address______________________________(City)____________(State)_____ (Zip) ________

Phone (Home)_________________________________(Cell) __________________________________

Employer: ____________________________________

Is the Insured the same as the Responsible Party? Y or N If no, Fill out below:

Name (Last)__________________(First, Middle Initial)____________________DOB____/____/_____

Relationship to Patient: ____

Social Security #______________________________ Marital Status: S M D W Sex: M F

Mailing Address______________________________(City)____________(State)______(Zip) _______

Phone (Home)_________________________________(Cell) _________________________________

Emergency Contact

Name (Last)___________________(First)_____________________Relation to Patient______________

Phone(Home)__________________(Work)____________________(Cell)________________________

Primary Care Physician or Pediatrician________________________

Who may we thank for this referral? _________________________

Allen Office: 1111Raintree Circle Suite 280 | Allen, Texas 75013
McKinney Office: 5220 W. University Drive Suite 150, Professional Office Building 2 | McKinney,Texas 75071
Plano Office: 4001 W. 15th Street Suite 225 | Plano, Texas 75093
Phone: (972) 984-1050 | Fax: (972) 984-1376 | www.entTX.com

If the patient is under 18, who do you authorize to bring your child to their appointment?
____

Who may we discuss your protected health information with (i.e, appointments, results)? Please be specific____

Pharmacy Information

What Pharmacy will you be using? Name_____________________Cross Streets____________________

*Please note prescriptions will be sent electronically to the pharmacy you listed. If you need the prescriptions sent to a different pharmacy please let us know before the prescription is sent.

Reminder Messages

We have a reminder system that will either text, email, or call you to remind you of your appointments. Please select how you would like to be reminded for appointments?

____Text to Mobile Number: ______________________________________

____Email to this address: ____

____Leave a message at this number: ________________________________

Acknowledgement of Receipt of Notice of Privacy Practice and Financial Policy

I have read the notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these specialized procedures and equipment are available only through a specialist and that the claim for the visit will be filed to the insurance on my behalf. I understand there are other procedures which may be performed as part of my diagnosis or treatment that may not be listed. I will be responsible for any amount not covered by my insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify The Ear Nose & Throat Centers of Texas of any changes in my insurance coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

By signing this document, I also acknowledge that I have read a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of privacy rights. Please note we do not give out any patient information to 3rd party organizations. **If you would like a copy of the Privacy Practices and/or Financial Policy please see the front office staff.**

I acknowledge that I have read the office's Notice of Privacy Practices and Financial Policy

Name (Print) ___________________________________

Date of Birth ___________________________________

Signature ______________________________________

Date ____

Allen Office: 1111Raintree Circle Suite 280 | Allen, Texas 75013
McKinney Office: 5220 W. University Drive Suite 150, Professional Office Building 2 | McKinney,Texas 75071
Plano Office: 4001 W. 15th Street Suite 225 | Plano, Texas 75093
Phone: (972) 984-1050 | Fax: (972) 984-1376 | www.entTX.com