

Texas Sinus Center

PATIENT REGISTRATION

**1. PATIENT INFORMATION**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status S / M / W / D    Student FT / PT    Male / Female    Occupation \_\_\_\_\_

Other family members at our office? Y / N    List names \_\_\_\_\_

Primary care physician \_\_\_\_\_    Were you referred to our office? YES / NO

If yes, referred by:  Dr. \_\_\_\_\_  Patient \_\_\_\_\_  My insurance company

Newspaper Ad     Google/Internet     TV Ad     Radio Ad     Website banner Ad     Billboard     Other

EMAIL ADDRESS \_\_\_\_\_    Would you like to receive email from us? Y / N

**2. RESPONSIBLE PARTY**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**3. INSURED/POLICY HOLDER INFORMATION**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**4. EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**5. RECEIPT OF NOTICE PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I, \_\_\_\_\_, have read a copy of Texas Sinus Center notice of Privacy Practices.

**6. AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of an original.

I hereby authorize Texas Sinus Center PA to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made to Texas Sinus Center.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any payments sent to me by my insurance company will be forwarded to the Texas Sinus Center to be applied toward my account should a balance exist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Please circle if applicable Parent or Guardian)

## **NEW PATIENT HEALTH HISTORY**

DATE \_\_\_\_\_ (STAFF REVIEW \_\_\_\_\_)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Has your insurance changed? \_\_\_yes \_\_\_no Has your address or personal information changed? \_\_\_yes \_\_\_no

Pharmacy name, phone number & location \_\_\_\_\_

Please describe the reason for visit \_\_\_\_\_

Have you been seen in our office before? \_\_\_yes \_\_\_no

Were you referred to our office? \_\_\_ yes \_\_\_no If yes, referring doctor: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_lbs

### **PLEASE TELL US ABOUT TODAY PROBLEM & SYMPTOMS**

When did your symptoms begin? \_\_\_\_\_ day(s) ago \_\_\_\_\_ week(s) ago \_\_\_\_\_ year(s) ago

Was there any precipitating event or circumstances that contributed or caused your problem?

How many times a year do you get sick? \_\_\_\_\_ 1-2 times \_\_\_\_\_ 3-4 times \_\_\_\_\_ 5-6 \_\_\_\_\_ 6+ times per year.

My symptoms are experienced (pick one)

My symptoms are worse in the (circle one):

\_\_\_\_\_ Symptoms have recently become constant.

Winter | Spring | Summer | Fall | All year

\_\_\_\_\_ Symptoms are experienced intermittently.

\_\_\_\_\_ My symptoms have resolved.

Please rate your symptoms? (circle one) Mild | Mild to Moderate | Moderate | Moderate to Severe | Severe

What medications have you taken for this problem?

(Please list all antibiotics, over the counter and prescription medications used for this problem.)

1. \_\_\_\_\_

4. \_\_\_\_\_

2. \_\_\_\_\_

5. \_\_\_\_\_

3. \_\_\_\_\_

6. \_\_\_\_\_

How did you respond to the medication(s) and/or treatment(s) you've taken for this problem?

\_\_\_\_\_ These medications did not help.

\_\_\_\_\_ These medications helped for a while but are not longer working.

\_\_\_\_\_ I only improved slightly with these medications.

\_\_\_\_\_ These medication helped.

Are you currently using any of the following: \_\_\_ Sinus Rinses, \_\_\_ Allergy Drops, \_\_\_ Allergy Shots

Do you have a history of: \_\_\_ Eczema/Asthma, \_\_\_ Environmental Allergies, \_\_\_ Reflux, \_\_\_ Migraine

**TODAY'S SYMPTOMS INCLUDE**

**GENERAL**

- Fever
- Fatigue
- Muscle aches

**THROAT**

- Trouble swallowing liquids
- Trouble swallowing solids
- Sore throat
- Hoarseness, change in voice
- Something stuck in my throat
- Frequent throat clearing

**NOSE & SINUS**

- Tooth pain
- Congestion
- Post nasal drip
- Sneezing
- Previous Trauma
- Can't smell
- Snoring

**HEAD**

- Dizziness
- Headaches  
(If checked please tell us where.)
- Forehead  
(circle) right left both sides
- Between eyes  
(circle) right left both sides
- Temples  
(circle) right left both sides
- Back of head  
(circle) right left both sides
- Top of head  
(circle) right left both sides

- Runny nose  
(If checked please tell us color.)
- Clear
- Green / Yellow
- Both clear and colored
- Bloody

Other nasal or sinus symptoms: \_\_\_\_\_

**EAR(S)**

- Ear trauma  
(circle) right left both sides
- I wear hearing aids  
(circle) right left both ears
- Ear pain (circle) right left both sides
- Ear popping  
(circle) right left both sides
- Ear fullness  
(circle) right left both sides
- Ringing  
(circle) right left both sides
- Itchy  
(circle) right left both sides
- Decreased hearing  
(circle) right left both sides
- Ear wax  
(circle) right left both sides

- Sinus Pressure  
(If checked please tell us where.)
- Forehead
- Cheek(s)
- Temple(s)
- Behind/between eye(s)

**EYE(S)**

- Watery  
(circle) right left both
- Itchy  
(circle) right left both
- Dry  
(circle) right left both
- Hoarseness  
(circle) right left both

**LUNGS:**

- Wheezing
- Cough
- Difficulty breathing

- I have trouble breathing out my nose
- Worse on right
- Worse on left
- Both sides
- Nosebleeds
- Right sided
- Left sided
- Both sides

Please check other symptoms that may bother you but that you are **NOT** experiencing today

- |  |  |   |  |                                       |
|--|--|---|--|---------------------------------------|
| <input type="checkbox"/> None            | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Itchy/dry skin | <input type="checkbox"/> Itchy watery eyes   | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Weakness        | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Chronic pain   | <input type="checkbox"/> Runny/Stuffy Nose   | <input type="checkbox"/> Sore Throat  |
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Wheezing        | <input type="checkbox"/> Sneezing       | <input type="checkbox"/> Urinary problems    | <input type="checkbox"/> Rash         |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Cough           | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Hives        |
|  | <input type="checkbox"/> Eye problems    | <input type="checkbox"/> Heart burn     | <input type="checkbox"/> Nausea / Vomiting   | <input type="checkbox"/> Fever/Chills |

Other \_\_\_\_\_

**MEDICATION ALLERGIES** (check all that apply)

- I am not allergic to any medications that I am aware of.
- |                                     |  |                                  |                                  |                                      |
|-------------------------------------|--|----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Cephalosporin's | <input type="checkbox"/> Sulfa   | <input type="checkbox"/> Tetanus | <input type="checkbox"/> IV Contrast |
| <input type="checkbox"/> Latex      | <input type="checkbox"/> Lidocaine       | Describe type of reaction: _____ |                                  |                                      |

Please list any other medication you are allergic to: \_\_\_\_\_

**PRESENT MEDICATIONS (not those listed above)**

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

**PAST MEDICAL HISTORY** (check all that apply)

None  Heart Disease  Diabetes  Asthma  Acid Reflux  
 High Blood Pressure  Arrhythmia  Thyroid Problems  COPD  Cancer  
 Increased Cholesterol  Other: \_\_\_\_\_

**PAST SURGICAL HISTORY** (check all that apply)

Ear Tubes  Ear Surgery  Appendectomy  CABG  Knee Surgery  
 Adenoids  Neck Surgery  Gall Bladder  Angioplasty  Hip Surgery  
 Tonsils  Thyroid Surgery  Hysterectomy  Angioplasty with stent  Back Surgery  
 Septoplasty  Eye Surgery  C-Section  Heart Valve  Shoulder Surgery  
 Sinus surgery  Breast Surgery  Abdominal Surgery  
 None  Other : \_\_\_\_\_

**SOCIAL HISTORY**

Alcohol usage:  none  occasionally  daily

Smoking: Do you currently smoke/use tobacco products?  yes  no  
If yes, for how many years? \_\_\_\_\_ Average packs/day? \_\_\_\_\_  
Are you a former smoker?  yes  no  
If yes, how long ago did you quit: \_\_\_\_\_  
Second-hand smoke history:  none  currently exposed

Work History:  Work Full-time  Work Part time  Student  Retired  Disability  N/A

Occupation: \_\_\_\_\_

**FAMILY HISTORY** (check all that apply)

<u>Allergic Rhinitis</u>	<u>Cardiac</u>	<u>Cancer</u>	<u>Diabetes</u>	<u>Bleeding Problem</u>
<input type="checkbox"/> No Family History	<input type="checkbox"/> No Family History	<input type="checkbox"/> No Family History	<input type="checkbox"/> No Family History	<input type="checkbox"/> No Family History
<input type="checkbox"/> Mother	<input type="checkbox"/> Mother	<input type="checkbox"/> Mother	<input type="checkbox"/> Mother	<input type="checkbox"/> Mother
<input type="checkbox"/> Father	<input type="checkbox"/> Father	<input type="checkbox"/> Father	<input type="checkbox"/> Father	<input type="checkbox"/> Father
<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Sibling(s)
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)

**Thank You**

ADVANCED BENEFICIARY NOTICE

**DIAGNOSTIC PROCEDURES**

IT IS THE GOAL OF THE PHYSICIANS AT THE TEXAS SINUS CENTER TO OFFER YOU THE BEST TREATMENT PLAN BASED ON THE MOST ACCURATE DIAGNOSIS. TO OBTAIN THIS DIAGNOSIS OUR DOCTORS MAY RECOMMEND PROCEDURES OR TESTS TO BE PERFORMED DURING YOUR VISIT. THESE PROCEDURES MAY INCLUDE, BUT ARE NOT LIMITED TO:

- **NASAL ENDOSCOPY – AN IN OFFICE SURGICAL PROCEDURE USING A STERILE SMALL CAMERA TO EXAMINE THE NASAL CAVITY.**
- **LARYNGOSCOPY – AN IN OFFICE SURGICAL PROCEDURE USING A STERILE SMALL CAMERA TO EXAMINE THE LARYNX (THROAT).**
- **COMPREHENSIVE HEARING TESTS**

DEPENDING ON YOUR INSURANCE COMPANY'S RULES AND REGULATIONS, YOU MAY BE FINANCIALLY RESPONSIBLE FOR SOME OR ALL OF THE COST OF THESE PROCEDURES. THESE PROCEDURES ARE BILLED AS SURGERY CHARGES, BUT THERE IS NO SURGERY INVOLVED. IT CAN BE A BIT CONFUSING WHEN YOU GET YOUR BILL.

**I UNDERSTAND THAT MY CO-PAY IS FOR A ROUTINE OFFICE VISIT. ADDITIONAL DIAGNOSTIC PROCEDURES (BILLED AS OFFICE SURGERY) AND TESTS ARE NOT INCLUDED IN A ROUTINE OFFICE VISIT AND WILL RESULT IN ADDITIONAL CHARGES. I WILL ASSUME FINANCIAL RESPONSIBILITY FOR CHARGES THAT MAY BE BILLED TO ME AS A RESULT OF ANY DIAGNOSTIC PROCEDURES / TESTS PERFORMED. DEPENDING ON MY SPECIFIC BENEFIT PLAN THE PROCEDURE / TEST CHARGES MAY BE APPLIED TO AN ANNUAL DEDUCTIBLE OR CO-INSURANCE.**

OR

**I DO NOT AUTHORIZE ANY PROCEDURES / TESTS TO BE PERFORMED DURING THIS VISIT, AND BY DOING SO, I UNDERSTAND THAT THIS MAY LIMIT THE INFORMATION THE DOCTOR HAS AVAILABLE TO DETERMINE THE DIAGNOSIS AND SUBSEQUENT TREATMENT.**

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S / LEGAL GUARDIAN'S SIGNATURE

## **FINANCIAL POLICY**

- 1. ALL CO-PAYS FOR OFFICE VISITS ARE DUE AT THE TIME OF VISIT.**
  
- 2. WE WILL PROCESS YOUR CLAIM FOR SERVICES.**
  
- 3. WHEN YOUR INSURANCE COMPANY HAS PROCESSED YOUR CLAIM YOU WILL BE EXPECTED TO PAY ANY OUTSTANDING BALANCE(S).**
  
- 4. ALL OUTSTANDING BALANCES OWED BY YOU OR YOUR FAMILY MEMBERS WILL BE PAID BEFORE ANY ADDITIONAL SERVICES CAN BE RENDERED.**
  
- 5. PLEASE BE AWARE THAT OUR OFFICE CHARGES FOR THE FOLLOWING SERVICES.**

**\$25.00 FOR MEDICAL RECORDS**

**\$25.00 FOR FAMILY LEAVE, WORK OR SCHOOL FORMS**

**NOTE: ABSOLUTELY NO FAMILY LEAVE, SCHOOL OR WORK FORMS WILL BE FILLED OUT 3 MONTHS AFTER YOUR DATE OF SURGERY OR IF IT HAS BEEN MORE THAN 3 MONTHS SINCE YOUR LAST OFFICE VISIT.**

\_\_\_\_\_  
**RESPONSIBLE PARTY (PRINT  
NAME)**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**RESPONSIBLE PARTY  
(SIGNATURE)**

\_\_\_\_\_  
**DATE**