WAYS TO COMPLETE PATIENT INFORMATION PACKET AHEAD OF YOUR APPOINTMENT:

1. PRINT FORM AND FILL OUT BY HAND.

2. COMPLETE FIELDS USING A PDF READER AND THEN PRINT.

3. COMPLETE FIELDS USING A PDF READER AND SAVE TO YOUR MOBILE DEVICE OR DESKTOP AS A PDF FILE, THEN EMAIL PDF FILE TO SCHEDULING@ENTLUBBOCK.COM

**PLEASE NOTE THAT THIS IS NOT A PATIENT PORTAL AND ANSWERS DO NOT AUTOMATICALLY TRANSMIT INTO OUR SYSTEM.

Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

PATIENT INFORMATION (ADULT)

Chart: _____

**EMAIL COMPLETED FORMS TO: SCHEDULING@ENTLUBBOCK.COM

Last Name _____ First Name _____ Middle Name _____ Suffix _____

Date of Birth _____ ☐ male ☐ female Marital Status _____ SS# _____

Street / Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone (with Area Code) _____ Cell Phone (with Area Code) _____ Work Phone (with Area Code) _____

May we contact you via email? ☐ No ☐ Yes Email address: _____

Employer _____ Occupation _____

Employer's Street Address _____ City _____ State _____ Zip _____

Race: ☐ Native American/Alaskan ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Spouse or Emergency Contact _____ Relationship _____ Phone Number (with area code) _____

Insured Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ ☐ male ☐ female Marital Status _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone (with Area Code) _____ Work Phone (with Area Code) _____

Employer _____ Employer Address _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referring Physician _____ Phone (with Area Code) _____

Family/Primary Physician _____ Phone (with Area Code) _____

Preferred Pharmacy _____ Location _____ Phone (with Area Code) _____

How did you hear about us? ☐ Physician referral ☐ TV/Online Ad ☐ Web Search ☐ Other _____

Payment of Fees: Necessary forms will be completed to help expedite insurance carrier payment to our office. By signing this form, I indicate that I understand my patient responsibility as outlined in the Ear Nose and Throat Associates Financial Policy (copy available at www.entlubbock.com or upon request). Fees are due and payable at the time services are rendered, unless other arrangements have been made in advance with our office manager. I also understand that my account may be referred to collections if balances are not paid in full.

Insurance Authorization & Assignment: I hereby authorize Ear Nose & Throat Associates of Lubbock, P.A. to furnish information to the insurance carrier concerning my illness and treatments, and I hereby assign to the physician all payments for medical services performed by this office and rendered to myself or my dependents. In the event that payment must be issued to the policy holder as stated in my contract, I authorize this payment be mailed to the provider of services. I understand that I am responsible for my copay, deductible, coinsurance and out of pocket maximums, as well as any services denied or not covered by my insurance company.

Signature _____ **Date**_____

(If completing online you may submit unsigned form and then sign upon arrival)

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AUTHORIZATION FOR COMMUNICATION OF HEALTH INFORMATION

I have been informed and agree to the procedures by which this office may communicate my protected health information. I hereby consent to communication via:

□ Email: _____

□ Voice message on the following telecommunication lines:

_____ _____

OPTIONAL AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

My protected health information may be discussed with or released to the following family members and/or personal acquaintances:

1.) Name _____ Relationship _____

2.) Name _____ Relationship _____

3.) Name _____ Relationship _____

Please note that without this authorization, this office cannot discuss medical issues with spouses, children, etc. who may inquire on behalf of the patient, an exception being custodial parents of children under the age of 18 and/or personal representatives of incapacitated patients. You may be required to fill out an additional form to release records to other entities, including physician offices, etc.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices and this signed document.

ACKNOWLEDGEMENT AND AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way related to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will all lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

_____ _____
Patient's Name (Print) Date

_____ _____
Patient/Personal Representative (Signature) Relationship to Patient
*if completing online, you may leave blank and sign upon appointment arrival

This notice is good for 3 years from the date of completion. Authorization may be revoked at any time by providing written notice to our office or completing a new acknowledgement form.

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Name _____ DOB _____ Age _____ Sex ☐ M ☐ F
Date _____ Height _____ Weight _____ Chart# _____

1) Describe the **major reason** for today's visit: _____
_____
_____
_____

How long has this been present? _____ Days _____ weeks _____ months _____ years
Any previous episodes? □ Yes □ No When: _____
Prior treatment? □ Over-the-counter medicines: _____
□ Prescription medicines: _____
□ Previous doctors visited: _____

2) Is there a **second problem** you would like evaluated? _____
_____
_____

Any previous episodes? □ Yes □ No When: _____
Prior treatment? □ Over-the-counter medicines: _____
□ Prescription medicines: _____
□ Previous doctors visited: _____

3) Illnesses: Do you have or have you ever had any of the following? Please check all that apply.

□ Chronic lung disease
□ Asthma
□ Recent Pneumonia
□ Diabetes: □ Type I □ Type II
□ Kidney Disease
□ High Blood Pressure
□ Previous Stroke
□ Gastric Ulcers
□ Migraine Headaches
□ Allergies
□ Chronic Ear Infections
□ Chronic Sinusitis
□ Thyroid Disease
□ Arthritis
□ Recent Dental Issues
□ HIV
□ Seizure Disorder
Specify_____
□ Anesthesia Reaction
Specify_____
□ Bleeding Disorder
Specify_____
□ Cancer
Specify_____
□ Heart Disease or heart attack
Specify_____
□ Hepatitis
Specify_____
□ Other
Specify_____
_____
_____

Any significant or recent hospitalizations? □ Yes □ No
Please explain: _____

_____

4) Surgeries: Have you ever had any of these surgeries? Please check all that apply and, if possible, give the date (month and/or year).

□ Tonsillectomy
□ Adenoidectomy
□ Ear Tubes
□ Septoplasty
□ Thyroidectomy
□ Cholecystectomy
□ Appendectomy
□ Hysterectomy
□ Prostatectomy
□ Hemorrhoidectomy
□ Hernia Repair

□ Other Throat Surgery
Specify_____
□ Neck Surgery
Specify_____
□ Other Ear Surgery
Specify_____
□ Previous Sinus Surgery
Specify_____
□ Cardiac Procedures
Specify_____
_____
_____

Please list any other surgeries: _____

_____

5) Medications: Please list prescription medications being taken.

Medication	Strength	How many times per day?

Please list over-the-counter medication being taken.

Medication	Strength	How many times per day?

Do you take prescription blood thinners, aspirin or fish oil? □ Yes □ No
Specify _____

6) Allergies: Allergies to medications

Penicillin □ Yes □ No Reaction: _____
Codeine □ Yes □ No Reaction: _____
Sulfa □ Yes □ No Reaction: _____
Other: _____ Reaction: _____
Other: _____ Reaction: _____
Other: _____ Reaction: _____

Allergies to medical products like tape, iodine, or latex? □ Yes □ No
Specify: _____ Reaction: _____

7) Social History:

Does your religion prohibit you from receiving blood products or blood transfusions? □ Yes □ No
**If yes, please be sure to discuss this with the doctor at the time of your evaluation.*

Occupation: _____
Exposure to loud noises? □ Yes □ No Specify: _____

Smokers in the home? □ Yes □ No If yes: □ Smokes Inside □ Smokes Outside
Do you or have you ever smoked? □ Yes □ No
□ 10/day □ 20/day □ 30/day □ 40/day If more please specify: _____/day
Age you started: _____ Age you quit: _____

Do you drink alcohol? □ Currently □ Socially □ Occasionally □ Rare □ Never

Recreational drug use? □ Never □ Previously □ Currently, specify _____

8) Review of Systems: Please check any of the following symptoms you *currently* have.

Ears	**Nose**	**Throat**	**Other**
□ Hearing loss	□ Difficulty breathing	□ Sore throat	□ Shortness of breath
□ Ringing in ear	□ Allergies	□ Acid Reflux	□ Persistent Cough
□ Dizziness/vertigo	□ Sinus drainage	□ Snoring	□ Bloody sputum
□ Ear drainage	□ Nose bleeds	□ Apnea	□ Wheezing
□ Ear infections	□ Headaches	□ Difficulty Swallowing	□ Chest pain
□ Ear pain	□ Injury	□ Painful Swallowing	□ Heart Palpitations
□ Hole in eardrum	□ Sinusitis	□ Hoarseness	□ Ankle swelling
□ Speech delay	□ Congestion	□ Neck masses/nodes	□ Stomach pain
		□ Thyroid problems	□ Fever
			□ Problems with urination or bowel movements

9) Family History: Please report significant family medical history in this section.

History:	**Specify Family Member (i.e. maternal grandmother, paternal uncle):**
□ Anesthesia Reactions	_____
□ Birth Defects (specify type)	_____
□ Bleeding/Clotting Problems	_____
□ Cancer (specify type)	_____
□ Diabetes (specify type)	_____
□ Hearing Loss	_____
□ Heart disease	_____
□ Thyroid disease	_____