

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



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

PATIENT INFORMATION (CHILD)

Chart: _____

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

Last Name _____		First Name _____		Middle Name _____	Suffix _____
Date of Birth _____		SS# _____	Preferred Language (s) _____		
Street /Mailing Address _____		City _____	State _____	9 Digit Zip Code _____	
Preferred Phone (with Area Code) _____		May we contact you via email? <input type="checkbox"/> No <input type="checkbox"/> Yes		Email Address: _____	
Ethnicity:	Hispanic	Non-Hispanic	Declined		
Race:	Native American/Alaskan	Asian	Black	Caucasian	Pacific Islander
				Other	Declined

Father/ Guardian Name _____			Mother/ Guardian Name _____		
Date of Birth _____	SS# _____	Insured _____	Date of Birth _____	SS# _____	Insured _____
Street Address _____			Street Address _____		
City _____	State _____	Zip _____	City _____	State _____	Zip _____
Home Phone (with Area Code) _____			Home Phone (with Area Code) _____		
Cell Phone (with Area Code) _____			Cell Phone (with Area Code) _____		
Work Phone (with Area Code) _____			Work Phone (with Area Code) _____		
Employer _____			Employer _____		
Employer's Street Address _____			Employer's Street Address _____		
City _____	State _____	Zip _____	City _____	State _____	Zip _____

Referring Physician _____		Phone _____
Family / Primary Physician _____		Phone _____
Pharmacy _____	Location _____	Phone _____
Emergency Contact Other Than Parent or Guardian _____		Relationship _____
		Phone _____
How did you hear about us? <input type="checkbox"/> Physician Referral <input type="checkbox"/> TV/Online Ad <input type="checkbox"/> Web Search <input type="checkbox"/> Other _____		

Payment of Fees

If the patient is a minor, the person(s) scheduling and accompanying the patient to the appointment will be the responsible party and therefore is responsible for all payments. 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 insurance carriers 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 any amount not covered by insurance.

Signature _____ **Date** _____
 (If completing online, you may submit unsigned form and then sign upon arrival)

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.

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.

- | | |
|---|---|
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Seizure Disorder
Specify _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anesthesia Reaction
Specify _____ |
| <input type="checkbox"/> Recent Pneumonia | <input type="checkbox"/> Bleeding Disorder
Specify _____ |
| <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Cancer
Specify _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Disease or heart attack
Specify _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis
Specify _____ |
| <input type="checkbox"/> Previous Stroke | <input type="checkbox"/> Other
Specify _____ |
| <input type="checkbox"/> Gastric Ulcers | _____ |
| <input type="checkbox"/> Migraine Headaches | _____ |
| <input type="checkbox"/> Allergies | _____ |
| <input type="checkbox"/> Chronic Ear Infections | _____ |
| <input type="checkbox"/> Chronic Sinusitis | _____ |
| <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Recent Dental Issues | _____ |
| <input type="checkbox"/> HIV | _____ |

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).

- | | |
|---|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Other Throat Surgery
Specify _____ |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Neck Surgery
Specify _____ |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Other Ear Surgery
Specify _____ |
| <input type="checkbox"/> Septoplasty | <input type="checkbox"/> Previous Sinus Surgery
Specify _____ |
| <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Cardiac Procedures
Specify _____ |
| <input type="checkbox"/> Cholecystectomy | _____ |
| <input type="checkbox"/> Appendectomy | _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Prostatectomy | _____ |
| <input type="checkbox"/> Hemorrhoidectomy | _____ |
| <input type="checkbox"/> Hernia Repair | _____ |

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction: _____
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction: _____
Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> 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

- Hearing loss
- Ringing in ear
- Dizziness/vertigo
- Ear drainage
- Ear infections
- Ear pain
- Hole in eardrum
- Speech delay

Nose

- Difficulty breathing
- Allergies
- Sinus drainage
- Nose bleeds
- Headaches
- Injury
- Sinusitis
- Congestion

Throat

- Sore throat
- Acid Reflux
- Snoring
- Apnea
- Difficulty Swallowing
- Painful Swallowing
- Hoarseness
- Neck masses/nodes
- Thyroid problems

Other

- Shortness of breath
- Persistent Cough
- Bloody sputum
- Wheezing
- Chest pain
- Heart Palpitations
- Ankle swelling
- Stomach pain
- 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 _____