Patient Name:
Date of Birth:

MEDICATIONS Please list all medications you take, dosage & frequency

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY Please check all that apply or fill in the blank

Are you allergic to any medications? ❑ Yes ❑ No
If yes, please indicate what you are allergic to: _____
_____

Check if **you** have any of these problems:
❑ Asthma ❑ Diabetes ❑ Heart disease ❑ Hepatitis ❑ High Blood Pressure
❑High Cholesterol ❑ HIV or AIDS

Please list any other medical problems you may have: _____
_____

Please list any past surgeries: _____
_____

SOCIAL HISTORY

What is your occupation? _____

Have you smoked cigarettes? ❑ Yes ❑ No If yes, how many years? _____

Are you smoking now? ❑ Yes ❑ No If yes, how many packs? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many beers or single drinks per week? _____

FAMILY HISTORY

Check if the following problems are in your family:

	Father	Mother	Other (Please write in relation to you): _____	_____	_____
Cardiovascular					
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐
Other Cardiovascular: _____	☐	☐	☐	☐	☐
Cancer (what kind?):_____	☐	☐	☐	☐	☐
Pulmonary/Respiratory					
Asthma	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Other Respiratory:_____	☐	☐	☐	☐	☐
Gastrointestinal					
Hepatitis	☐	☐	☐	☐	☐
Other Gastrointestinal:_____	☐	☐	☐	☐	☐
Renal/Genitourinary					
Renal Failure	☐	☐	☐	☐	☐
Other Renal/Genitourinary:_____	☐	☐	☐	☐	☐
Neurological/Genetic					
Dementia	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Other Neurological/Genetic:_____	☐	☐	☐	☐	☐
Endocrine					
Diabetes	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐
Other Endocrine:_____	☐	☐	☐	☐	☐
Hematology_____	☐	☐	☐	☐	☐
Musculoskeletal					
Gout	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Other Musculoskeletal:_____	☐	☐	☐	☐	☐
Allergy/Immunology					
Allergies:_____	☐	☐	☐	☐	☐
AIDS/HIV+	☐	☐	☐	☐	☐
Other Allergy/Immunology:_____	☐	☐	☐	☐	☐
Psychiatric:_____	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

Please indicate your parent's health status:

Father: ☐ Alive ☐ Deceased

If deceased, of what did your father die? _____

Mother: ☐ Alive ☐ Deceased

If deceased, of what did your mother die? _____

ENT Partners of Texas

Patient: _____ **Date:** _____

Review of Systems-Adult Male/Female

Circle Response

Yes	No	
Constitutional		
Y	N	fever
Y	N	daytime sleepiness
Y	N	weight loss (unintentional)
Y	N	weight gain (unintentional)
Eyes		
Y	N	itchy eyes
Y	N	eye drainage
Ears/Nose/Throat		
Y	N	decreased hearing
Y	N	ringing in ears
Y	N	frequent ear infections
Y	N	nosebleeds
Y	N	nasal congestion
Y	N	sneezing
Y	N	itchy nose
Y	N	itchy throat
Y	N	frequent sore throat
Y	N	prolonged hoarseness
Cardiovascular		
Y	N	chest pain
Y	N	palpitations
Respiratory		
Y	N	cough (chronic)
Y	N	snoring
Gastrointestinal		
Y	N	difficulty swallowing
Y	N	heartburn
Genitourinary		
Y	N	blood in urine
Musculoskeletal		
Y	N	muscle weakness
Y	N	joint pain/stiffness
Y	N	back pain
Integumentary		
Y	N	rashes
Y	N	eczema
Neurological		
Y	N	frequent headaches
Y	N	difficulty sleeping
Y	N	problems with balance
Hematologic/Lymphatic		
Y	N	easy bruising
Y	N	excessive bleeding
Y	N	enlarged lymph nodes
Endocrine		
Y	N	excessive appetite
Y	N	heat/cold intolerance
Y	N	excessive sweating
Allergic/Immunologic		
Y	N	problems with anesthesia
Psychiatric		
Y	N	depression
Y	N	memory loss
Y	N	difficulty speaking

_____
Signature of person completing form

_____
Printed name

_____
Relationship to patient

ENT Partners *of* Texas

ADULT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____

Sex: M / F (Circle one) Married/Single/Divorced/Widow Spouse Name: _____

Date of Birth: _____/_____/_____ Spouse Cell Number: _____

Race/Ethnic Group _____ Preferred Language _____

Home Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____
(Street) (City/State/Zip)

E-mail Address: _____

Preferred Contact Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

Preferred Appt. Reminder Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

Drivers License # _____ Primary Care Physician: _____

Referring Physician: _____ Patient Referral: _____

Preferred Pharmacy: _____ Address: _____

Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

FIRST INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

(PLEASE COMPLETE BACK SIDE OF THIS FORM)

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

Who to call for an emergency:

Name: _____ Address: _____
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

MEDICATION HISTORY CONSENT

I authorize ENT Partners of Texas to obtain my medication history

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION FOR BILLING

I authorize treatment of the person named above and agree to pay all fees for such treatment. I also authorize the release of any medical information necessary to process these claims. I hereby authorize ENT Partners of Texas to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Coordinator or Privacy Officer. My signature acknowledges my receipt of the Notice of Privacy Practices for ENT Partners of Texas.

SIGNATURE: _____ DATE: _____

STUDENT OBSERVATION

I give my permission to have a student present with the physician during my appointment.
Please check one of the options concerning your consent.

_____ I give my permission for a student to be present with the physician during my visit.

_____ I decline permission for a student to be present with the physician during my visit.

Signature: _____ Date: _____

If you would like us to release your medical or billing records to anyone other than yourself, please complete the authorization below.
I authorize ENT Partners of Texas to release my ☐ medical ☐ billing ☐ other _____ information to the following person(s): _____

Patient Signature: _____ Authorization Expires: _____