1441 Redbud Blvd Suite 211 McKinney, TX 75069
Phone (469) 678-2211 ♦ Fax (469) 678-2253

# Patient Registration Form

***Please print clearly so that we can process your information quickly and efficiently. Thank you!***

***How did you hear about Texas Ear and Vestibular Institute?***

☐ Provider Referral ☐ Advertisement ☐ Friend ☐ Other: ________________________

**Today's Date: ____/____/____**

## PATIENT INFORMATION

Name: ______________________________________________________________________________
Last First MI

Date of Birth: ___________________ Age: ___________ Sex: ___ Height: ___________ Weight: _____________

Social Security Number: _______________________ Marital Status: ☐ M ☐ S ☐ W ☐ D

Address: _____________________________________________ City: __________ State: _____ Zip: ___________

Email: _______________________________________________________________________________________

Home Phone (____) ____________ Cell Phone (____) ________________ Business Phone (____) _________________

Primary Care Physician: _____________________________ Primary Care Physician No.: ______________________

Referring Physician: ________________________________ Referring Physician No.: _________________________

## INSURANCE INFORMATION

**Primary Medical Insurance**

Primary Insurance Company: ________________________

Policy Holder: _____________________________________

Policy Holder DOB: _________________________________

Relationship: ______________________________________

Policy No.: ________________________________________

Group No.: ________________________________________

**Secondary Medical Insurance**

Secondary Insurance Company: ______________________

Policy Holder: _____________________________________

Policy Holder DOB: _________________________________

Relationship: ______________________________________

Policy No.: ________________________________________

Group No.: ________________________________________

## GUARANTOR OR RESPONSIBLE PARTY *(IF NOT INSURED)*

☐ **Same as Patient Information *(If different, please complete section below)***

Name: _________________________ Date of Birth: ________________ Relationship: _________________________

Address: __________________________________________ City: ____________ State: _________ Zip: ___________

☐ Home No.: (____) ________________ ☐ Business No.: (____) ________________ ☐ Cell No.: (____) ________________

Employer: _________________________________________ Employer No.: ____________________________________

Employer Address: __________________________________ City: ____________ State: _________ Zip: __________

## EMERGENCY NOTIFICATION

Contact Person: ___________________________________ Relationship to Patient: ____________________________

Home No.: ________________________________________ Work No.: _________________________________________

## PREFERRED PHARMACY

Name of Pharmacy: ________________________________ Phone Number: ____________________________________

Address: _________________________________________________________________________________________

## RELEASE OF HEALTH INFORMATION

☐Texas Ear and Vestibular Institute **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws

☐Texas Ear and Vestibular Institute **MAY** discuss my healthcare and MAY discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name: _________________________ Relationship: ____________________ Phone: _________________________

Name: _________________________ Relationship: ____________________ Phone: _________________________

Name: _________________________ Relationship: ____________________ Phone: _________________________

I understand that if I would like to authorize Texas Ear and Vestibular Institute to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards

Patient Name: _______________________ Signature: __________________________ Date: ____/____/_____

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

☐No Expiration
☐Date of Expiration _______/_______/_______
☐Event: (Describe event upon which this Authorization will expire) __________________________________________

## PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:

☐Phone #: (________) __________ - ____________________
☐OK to leave message with detailed information
☐OK to leave message with contact number only
☐DO NOT LEAVE MESSAGE

**Briefly describe what brings you in for an appointment:** ____________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Please mark any medical conditions you have or have had in the past:**

- ☐ **NONE**
- ☐ **Abnormal heart rhythm**
- ☐ **Anxiety**
- ☐ **Asthma**
- ☐ **Arthritis**
- ☐ **Autoimmune Disease**
- ☐ **Benign Prostate Hypertrophy**
- ☐ **Cancer:** _________________
- ☐ **COPD/Lung Disease**
- ☐ **Congestive Heart Failure**
- ☐ **Coronary Artery Disease**
- ☐ **Dementia**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **GERD/Acid Reflux**
- ☐ **Headache Disorder**
- ☐ **Heart Attack**
- ☐ **Hepatitis**
- ☐ **High Cholesterol**
- ☐ **HIV/AIDS**
- ☐ **Hypertension/High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Thyroid Disorder**
- ☐ **Other:**

__________________________

__________________________

**Please list surgeries you have had, along with year if known:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Please check if you have previously been diagnosed with any of the following conditions:**

- ☐ **NONE**
- ☐ **Acoustic Neuroma**
- ☐ **Allergic Rhinitis**
- ☐ **Cholesteatoma**
- ☐ **Ear Infection**
- ☐ **Eustachian Tube Disorder**
- ☐ **GERD/Acid Reflux**
- ☐ **Hearing Loss**
- ☐ **Loss of Smell**
- ☐ **Mastoiditis**
- ☐ **Nasal Polyps**
- ☐ **Otosclerosis**
- ☐ **Seasonal Allergies**
- ☐ **Sinusitis**
- ☐ **Sleep Apnea**
- ☐ **Tinnitus**
- ☐ **Tonsillitis**
- ☐ **Vertigo**
- ☐ **Other Ear Disorder:** ____________________________
- ☐ **Other Nose Disorder:** ____________________________
- ☐ **Other Throat Disorder:** ____________________________
- ☐ **Other:** ____________________________

**Please list all medication that you take, along with dose (you may provide a separate list if you have one):**

| MEDICATION: | DOSAGE: | HOW MANY TIMES A DAY? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Are you allergic to any medications?** ☐**Yes** ☐**No**
**If allergic to medications, list them here:** ____________________________________________________________

**Do you smoke or use nicotine products?** ☐**Yes** ☐**No**
**If yes, please list type and how often:** ____________________________________________________________

**Do you drink alcohol?** ☐**Yes** ☐**No**
**If yes, please list how often:** ____________________________________________________________

**Do you drink caffeine?** ☐**Yes** ☐**No**
**If yes, please list how much:** ____________________________________________________________

**What is your occupation?** ___________________________________________________________

☐ **Full-Time** ☐ **Part-Time** ☐ **Self-Employed** ☐ **Student** ☐ **Retired**

**Family History – please list any conditions that run in your family:**

**ENT conditions:** ____________________________________ **Relative:** ______________________

**Other conditions:** __________________________________ **Relative:** ______________________

**Review of Systems: Please check if you have had any of the following symptoms:**

- ☐ **Dizziness**
- ☐ **Dry Mouth**
- ☐ **Difficulty Swallowing**
- ☐ **Voice Problems**
- ☐ **Ear Itching**
- ☐ **Hearing Loss**
- ☐ **Loss of Smell**
- ☐ **Ear Pain**
- ☐ **Drainage in Ears**
- ☐ **Runny Nose**
- ☐ **Sensitive to Loud Sounds**
- ☐ **Ringing in Ears**
- ☐ **Vertigo**
- ☐ **Chest Pains**
- ☐ **Shortness of Breath**
- ☐ **Increased Heart Rate**
- ☐ **Fatigue**
- ☐ **Fever**
- ☐ **Malaise**
- ☐ **Double Vision**
- ☐ **GERD/Heartburn**
- ☐ **Vomiting**
- ☐ **Loss of Mobility**
- ☐ **Swelling**
- ☐ **Confusion**
- ☐ **Headache**
- ☐ **Memory Loss**
- ☐ **Tremor**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Cough**
- ☐ **Shortness of Breath**
- ☐ **Wheezing**

**Review of Alerts: Please check if you have any of the following**

- ☐ **Allergy to Tape/Adhesives**
- ☐ **Allergy to Latex**
- ☐ **Allergy to Shellfish or Iodine**
- ☐ **Use of Blood Thinners**
- ☐ **Implanted Defibrillator**
- ☐ **Mechanical Heart Valve**
- ☐ **Pacemaker**
- ☐ **Currently Pregnant or Planning Pregnancy**
- ☐ **Recent Chemotherapy**
- ☐ **Under Pain Management**
- ☐ **Undergoing Radiation Therapy**
- ☐ **Other Alert You Want Us to Know:**

___________________________________

## TEVI POLICES AND CONSENT TO TREAT

(_____)
**Initial**

**Missed Appointments:** Your appointment time is set aside especially for you. Resources are assigned for each individual patient. We ask that for the courtesy to the Doctor and to other patients that you keep your scheduled appointments.

**If you must change or miss an appointment, we require a 24-hour notice. Failure to provide a 24-hour notice to cancel your scheduled appointment will result in a "no show" fee of $50.00 for office visits with Dr. Senchak or a $150 fee for specialty testing and procedures. A no-show fee must be paid prior to being seen at your next visit. Please note that insurance companies do not pay for no-show fees and therefore will not be billed for that charge.**

(_____)
**Initial**

**Consent of Treatment:** I authorize the staff at Texas Ear and Vestibular Institute to provide any diagnostic tests and examination indicated for treatment.

(_____)
**Initial**

**Disability or Insurance Forms:** There will be a charge of $25 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.

(_____)
**Initial**

**Medication Policy Consent:** I authorize Texas Ear and Vestibular Institute to obtain a medication history and/or list of current medications via my pharmacy for my medical records.

## FINANCIAL RESPONSIBILITY AGREEMENT

(_____)
**Initial**

I hereby assign, transfer, and set over to Texas Ear and Vestibular Institute all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. All deductibles and co-pays are due at the time services are rendered and will be collected based on the information provided by your insurance company. I understand that charges not covered by my insurance company or my secondary insurance if applicable, as well as any applicable co-payments, co-insurance, and deductibles are my responsibility. If your insurance is with an HMO or other managed care program, Texas Ear and Vestibular will bill them only if you present an appropriate authorization form. If you do not have an appropriate authorization form for each visit, you will be responsible for all charges during that visit. If your insurance company has not paid your account in 90 days, the balance may be transferred to you for payment.

Insurance companies whom we are not participating with will fall under the patient responsibility for the first date of service, Texas Ear and Vestibular Institute will bill your insurance for all other visits. I understand that if I default on payment for services, my account may be transferred to an independent collection agency, designated as credit risk and payment for services will be required at the time of registration for all future visits. I have read the financial policy as above. I understand and agree to above financial policy.

We currently accept cash, Visa, Mastercard, Discover, American Express and Care Credit. Unfortunately, we are not accepting checks at this time. If you have any questions regarding your bill, please contact our billing department at 469-625-2879.

## AUTHORIZATION TO RELEASE INFORMATION

(_____)
**Initial**

I hereby authorize Texas Ear and Vestibular Institute to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used in processing insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Ear and Vestibular Institute. On behalf of myself and/or my dependents, and understand that my making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(_____)
**Initial**

I acknowledge that I have received a copy of the Notice of Privacy Practices and understand my rights as a patient of Texas Ear and Vestibular Institute.

With my consent, Texas Ear and Vestibular Institute may use and disclose of my protected health information protected under Health Insurance Portability and Accountability Act of 1996 for treatment, billing/payment, and health care operations.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while Texas Ear and Vestibular Institute is not required to agree to my requested restrictions, if does agree, it is bound by that agreement.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand Texas Ear and Vestibular Institute may refuse me further service if I revoke the consent.

**I _________________________________ have read or have had someone read to me the Texas Ear and Vestibular Institute Policies and Procedure listed above. By signing below and initialing the spaces above I am giving my consent to treat, comply and assign my visits to my insurance company or the guarantor.**

_____________________________________________ **Patients Signature**

_________________________ **Todays Date**