Otolaryngology Specialists of North Texas

Pediatric and Adult Ear, Nose, & Throat Specialists

Dr. Rohn and Dr. Gamble
6300 W Parker Rd Suite G24
Plano, TX 75093
972-378-0633

7515 Greenville Ave Suite 410
Dallas, TX 75231
214-239-1641

Patient Intake Form- Adult

Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Date of Birth ____/____/_____

Age _____ Sex _____ SSN :_____Race _____ Ethnicity ____Hispanic _____Not Hispanic

Address _____ Apt # _____ City _____ State _____ Zip _____

Email Address _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Work Phone _____

How may our office best contact you? (check one) _____Home Phone _____Cell Phone _____Work Phone

Preferred method of appointment reminder? _____Text _____Phone (circle: cell or home)

Occupation _____ Employer _____

PHARMACY

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

INSURANCE INFORMATION

Primary Insurance Carrier _____

ID# _____ _____

Group # _____

Subscriber Name _____

Subscriber SS # _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

Secondary Insurance Carrier _____

ID# _____

Group # _____

Subscriber Name _____

Subscriber SS# _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

REFERRING PHYSICIAN

Physician Name _____ Practice Phone _____

May we thank someone else (non-physician) for referring you to our office? _____

ALLERGY INFORMATION

Drug Allergies _____Environmental Allergies_____

Are you allergic to latex? _____ Yes _____ No

Are you allergic to medical tape? _____ Yes _____ No

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Exercise: Yes _____No_____ How often: Daily_____2-3x a week_____3-4x a week_____

Use Alcohol: Never_____1 a month_____2-4 a month_____2-3 a week_____4+ a week ____Number in one occasion_____

How often did you have 6+ drinks on one occasion in the past year: Never_____ Monthly_____ Weekly_____ Daily _____

Do you CURRENTLY smoke or use tobacco products: Yes___ No ___What do you use_____ How often ____Daily ____Occ.

Have you EVER smoked or used tobacco products: Yes_____ No_____ How often did you use: Everyday____ Occasionally_____

How much _____ How many years _____When did you quit _____What did you use _____

Have you used drugs in the last 12 months (Marijuana/Heroin/LSD/Cocaine/Other) Yes_____ No_____

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication_____ Reason for Taking _____Medication_____ Reason _____

Medication_____ Reason for Taking _____Medication _____Reason_____

Medication_____ Reason for Taking _____Medication _____Reason _____

HEALTH HISTORY

What problems are you here for today? _____

Do you currently have or frequently experience:

____Alcoholism
____Anemia
____Arthritis
____Atrial Fibrillation
____Asthma
____Birth Defects
____Bladder Disease
____Bleeding Disorder
____Cancer
____Depression
____Diabetes
____Emphysema
____Epilepsy/Seizures
____Glaucoma
____Headaches
____Heart Attack
____Heart Failure
____Hepatitis
____High Blood Pressure
____High Cholesterol
____HIV/AIDS
____Kidney Disease
____Liver Problem
____Lung Problem
____Mental Illness
____Reflux
____Sleep Apnea
____ Stroke
____ Thyroid Problem
____ Tuberculosis
____Weight Loss/Gain
____Other:_____

Have you undergone any of the following surgeries?

Tonsillectomy Date:_____
Ear Surgery Date:_____
Ear Tubes Date:_____
Adenoidectomy Date:_____
Thyroid Surgery Date:_____
Nasal/Sinus Surgery Date:_____
Other: _____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S=Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM= Paternal Grandmother, or PGF= Paternal Grandfather

____Alcoholism
____Anemia
____Arthritis
____Atrial Fibrillation
____Asthma
____Birth Defects
____Bladder Disease
____Bleeding Disorder
____Cancer
____Depression
____Diabetes
____Emphysema
____Epilepsy/Seizures
____Glaucoma
____Headaches
____Heart Attack
____Heart Failure
____Hepatitis
____High Blood Pressure
____High Cholesterol
____HIV/AIDS
____Kidney Disease
____Liver Problem
____Lung Problem
____Mental Illness
____Reflux
____Sleep Apnea
____ Stroke
____ Thyroid Problem
____ Tuberculosis
____Weight Loss/Gain
____Other:_____

Patient Name:_____Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: _____Healthy _____Change in appetite _____ Fever _____
Do you frequently have or frequently experience: (Please check ALL that apply)

Allergy/Immunologic	**____None**	____Reactions	____Sneezing	____Eye Irritation
		____Other:_____		
Eyes	**____None**	____Irritation from light	____ Blurred Vision	____Other_____
Ears, Nose, Throat & Mouth	**____None**	____Itching Nose	____Rhinitis	____ Bruxism (teeth grind)
		____ Nose Blocked	**____**Sores in Mouth	____Post Nasal Drip
		____Teeth Hurt	____Painful Swallowing	____Pressure in Ear
		____Hearing Loss	____Difficulty Swallowing	
Respiratory (Lungs)	**____None**	____Cough	____Shortness of Breath while sitting	
		____Wheezing	____Other:_____	
Cardiovascular (Heart)	____**None**	____Cyanosis	____Palpitations/Fluttering of Heart	
		____ Pain in Chest	____Shortness of Breath while exercising	
Gastrointestinal	**____None**	____Pain	**____**Constipation	____Diarrhea
		____Indigestion	____Other:_____	
Hematologic/Lymph Nodes	**____None**	____Bleeding Easily	____Night sweats	____Other:_____
Genitourinary	**____None**	____Hesitation when urinating		____Urination at Night
		____Pain when urinating		____Other:_____
Musculoskeletal	**____None**	____Cramping	____Soreness	____Weakness
		____Other:_____		
Integumentary	**____None**	**____**Dry Skin	____Itchy Skin	____Lesions on Skin
		____Bleeding	____Other:_____	
Neurological (Nerves)	**____None**	____ Dizziness/Vertigo	____Ringing in Ears	____Abnormal Movements
		____Twitch	____Other:_____	
Psychiatric	**____None**	____Situational Stress	____Depression	____Mood Swings
		____Anxiety	____Other:_____	
Endocrine	**____None**	**____**Hot Flashes	____Hair Loss/Growth	____Heat
		____Cold	____Other:_____	

Patient Comments: _____

_____

_____

Signature of Patient/Guardian _____Date_____

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6300 W Parker Rd, Suite G24 Plano, TX 75093
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Authorizations and Releases

By signing this consent form, I acknowledge that I have read, understand and/or authorize the following:

Authorization of Treatment:
I certify that I am the patient or the parent/legal guardian of the patient, and I consent to the administration and cost of all medical and surgical procedures, x-ray and medication for myself and for my dependents.

Guarantee of Payment:
_____ Initial if **SELF PAY**: I elect to pay for all services rendered in full on the date of treatment. I understand that my insurance will NOT be billed by Otolaryngology Specialists of North Texas (the "Practice").

_____ Initial if **INSURANCE** – **Assignment of Benefits:** I authorize payment directly to The Practice for all benefits otherwise payable to me. I also acknowledge that the Practice will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and current contract with my insurance carrier. I understand this is only an estimate, and, after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. I understand he Practice cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Receipt of Financial Policy:
By signing this consent form, I acknowledge that a copy of the Financial Policy of the Practice is available to me upon request and can be downloaded at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Receipt of Privacy Practices/HIPAA & Release of Health Information:
By signing this consent form, I acknowledge that a copy of the Practice's Notice of Privacy Practices ("NPP") has been made available to me, I am entitled to receive a copy upon request and I may download the NPP at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

I understand that the Practice may use and/or release my health information verbally, in writing, electronically or otherwise for treatment related functions, payment for services, for quality review purposes and any other purposes specifically permitted or required under HIPAA and as described in the Practice's NPP.

___I request my health information be shared with _____Relationship to Patient_____

I authorize the Practice to leave messages for the patient about appointment reminders or instructions regarding patient care at the following **phone number**: _____.

Surgery Center Disclosure:
I understand that the physicians of the Practice are affiliated as owners with, and have financial interest in the following surgery centers or hospitals: Texas Institute of Surgery, Texas Health Center for Diagnostics and Surgery and Cook Children's Pediatric Surgery Center). The physicians may receive an indirect financial benefit if you are referred to any of these facilities. I understand that I have the option to use an alternate facility and the Practice will not treat me differently if I choose to use an alternate facility.

I may revoke consent for any or all of the above items at any time, in writing. I certify that all information provided to the Practice is correct.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date