Texas Sinus Center

New Patient Registration

PATIENT INFORMATION

Today's Date: ___/___/___ Name: _____ Date of Birth: ___/___/___

Age: ____ Gender: M / F Social Security #: _____ Marital Status: M S D W

Address: _____ City: _____ State: _____ Zip

Code: _____ Home Phone #: _____Work Phone #: _____

Mobile Phone #: _____ Email address: _____

RESPONSIBLE PARTY

Name: _____ Date of Birth: ___/___/___ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact Number: _____ Cell Home Work

INSURED/POLICYHOLDER INFORMATION

Name: _____ Date of Birth: ___/___/___ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Contact Number: _____ Cell Home Work

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship to Patient: _____

FOR MINORS

Guardian/Responsible Party: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ Social Sec #: _____ Tel#: _____

Address (if different from patient's): _____

PHARMACY & REFERRALS

(Pharmacy information is REQUIRED- all prescriptions are sent electronically)

Pharmacy Name, Location & Phone:_____

Primary Care Physician's Name, Location & Phone: _____

Referring Physician's Name, Location & Phone: _____

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

_____

_____

RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Please read and review our HIPPA Privacy Practices which are included in this packet before signing.
I, _____, have read a copy of Texas Sinus Center notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of an original. I hereby authorize Texas Sinus Center PA to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made to Texas Sinus Center. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any payments sent to me by my insurance company will be forwarded to the Texas Sinus Center to be applied toward my account should a balance exist.

Signature_____ Date_____
(Please circle: Patient Parent or Guardian)

FINANCIAL POLICY

All co-pays for office visits are due at the time of visit.

We will process your claim for services.

When your insurance company has processed your claim you will be expected to pay any outstanding balance(s).
All outstanding balances owed by you or your family must be paid before any additional services are rendered.

Our providers schedules are generally full weeks in advance therefore, we ask that you call to cancel or reschedule 3 days prior to your appointment.

We charge $25.00 for failing to notify us of cancellation or not showing for follow up appointments .
We charge $50.00 for failing to show for an Allergy Test or CT appointment.

Please be aware that our office charges for the following services.

Minimum $25.00 for Medical records
Minimum $25.00 for Family Leave, Extended leave paperwork

NOTE: Absolutely no family leave, school or work excuses or forms will be granted 90 days after your surgery or it had been longer than 90 days since your last appointment.

___ /___ /___ _____ _____
Date Responsible Party (Print Name) Responsible Party (Signature)

CONSENT TO ACCESS MEDICATION RECORDS

For some patients it is possible for us to download your current medications from an online pharmacy database. Doing so helps us keep our records up to date and helps decrease prescribing errors.

I hereby give Texas Sinus Center permission to access my online pharmacy records to add a list of my medications to my records.

Signature:_____ Date: _____

ADVANCED BENEFICIARY NOTICE

Diagnostic Procedures

It is the goal of the Texas Sinus Center to offer you the best treatment plan based on the most accurate diagnosis. To obtain this diagnosis our providers may recommend procedures or tests to be performed during your visit. These procedures may include, but are not limited to:

- Nasal Endoscopy – an in office surgical procedure using a sterile small camera to examine the nasal cavity.
- Laryngoscopy – an in office surgical procedure using a sterile small camera to examine the larynx (throat).

Depending on your insurance company's rules and regulations, you may be financially responsible for some or all of the cost of these procedures. These procedures are billed as SURGERY CHARGES, but there is NO SURGERY involved. This can be a confusing when you get your bill. Call our office if you have questions regarding your bill.

_____ I understand that my co-pay is for a routine office visit. Additional diagnostic procedures (billed as office surgery) and tests are NOT included in a routine office visit and will result in additional charges. I will assume financial responsibility for charges that may be billed to me as a result of any diagnostic procedures / tests performed. Depending on my specific benefit plan the procedure / test charges may be applied to an annual deductible or co-insurance.

OR

_____ I do NOT authorize any procedures / tests to be performed during this visit, and by doing so, I understand that this may limit the information the doctor has available to determine the diagnosis and subsequent treatment.

CONSENT TO USE EMAIL AND CELL PHONE TEXTING

Texas Sinus Center uses email and texting as a way to communicate with our patients for the following reasons.

1. Medication Refills - We frequently communicate with patients about routine matters such as prescription status, medication refills etc.

2. Distribute Forms & Handouts - Patient registration documents, surgery information and medical handouts.

3. Communicate with you following procedures.

4. Important News - We send out 3-4 emails a year about important issues related to sinus/allergy problems.

If you give us your permission to use your email and text for the above, please sign, date and leave your email address and cell phone number below.
If you do not wish to receive emails or texts from us just leave the form blank. Please be reassured that we will never sell, rent or distribute your information to any third party.

Email address: _____ Cell Phone for Texting: _____

___/___/___ _____ _____

Date Responsible Party (Print Name) Responsible Party (Signature)

PLEASE TELL US ABOUT TODAY'S PROBLEM(S) & SYMPTOM(S)

Please describe the reason for visit_____

When did your symptoms begin? _____ day(s) ago _____ week(s) ago _____ year(s) ago

Were there any precipitating events or circumstances that contributed or caused your problem: _____

_____

How many times a year do you get sick? _____ 1-2 times _____ 3-4 times _____ 5+ per year.

My symptoms are experienced (pick one) _____ constantly _____ intermittently

My symptoms are? (circle one) Mild | Mild to Moderate | Moderate | Moderate to Severe | Severe

What medications have you taken **FOR THIS PROBLEM**?
(Please list all antibiotics, over the counter and prescription medications used for **this problem**.)

Medication	Dose/Frequency	Medication	Dose/Frequency
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

How did you respond to the medication(s) and/or treatment(s) you've taken for this problem?

_____ These medications did not help.
_____ These medications helped for a while but are not longer working.
_____ I only improved slightly with these medications.
_____ These medication helped.

Are you currently using any of the following: ____ Sinus Rinses ____ Allergy Drops ____ Allergy Shots

Have you ever been Allergy Tested? YES NO If yes, when were you last allergy tested? _____

Was the allergy test: POSITIVE NEGATIVE DON'T REMEMBER

Have you had any recent imaging of your sinuses? YES NO When?_____ Where?_____

MEDICAL HISTORY

Please check off any of the following medical conditions that you **CURRENTLY** have:

Cancer

- ☐ Cancer: Bone
- ☐ Cancer: Brain
- ☐ Cancer: Breast
- ☐ Cancer: Cervical
- ☐ Cancer: Chronic lymphocytic leukemia
- ☐ Cancer: Colon
- ☐ Cancer: Endometrial
- ☐ Cancer: Esophageal
- ☐ Cancer: Head and Neck
- ☐ Cancer: Leukemia
- ☐ Cancer: Liver
- ☐ Cancer: Lung
- ☐ Cancer: Lymphoma
- ☐ Cancer: Myeloma
- ☐ Cancer: Ovarian

- ☐ Cancer: Prostate
- ☐ Cancer: Pancreas
- ☐ Cancer: Sarcoma (soft tissue)
- ☐ Cancer: Skin - Basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - Merkel cell carcinoma
- ☐ Cancer: Skin, Squamous cell cancer
- ☐ Cancer: Other_____

CARDIO

- ☐ Cardio: Arrhythmia
- ☐ Cardio: Atrial fibrillation
- ☐ Cardio: Cardiomyopathy
- ☐ Cardio: Congestive heart failure
- ☐ Cardio: Coronary artery disease
- ☐ Cardio: Hyperlipidemia/High Cholesterol
- ☐ Cardio: Hypertension/High blood pressure
- ☐ Cardio: Myocardial infarction/Heart attack
- ☐ Cardio: Valve disease; valve prolapse, stenosis, or "leaky" valve
- ☐ Cardio: Other _____

ENDOCRINE

- ☐ Endocrine: Diabetes
- ☐ Endocrine: Diabetes, Type 1
- ☐ Endocrine: Diabetes, Type 2
- ☐ Endocrine: Pituitary adenoma or other pituitary problem
- ☐ Endocrine: Thyroid disease
- ☐ Endocrine: Other
- ☐ General: Eating disorder
- ☐ General: Obesity
- ☐ General: Sexually transmitted infection

GASTROENTEROLOGY

- ☐ GI: Barrett's Esophagus
- ☐ GI: Cholecystitis (gallbladder disease) or gallstones
- ☐ GI: Cirrhosis
- ☐ GI: Diverticulitis
- ☐ GI: Diverticulosis
- ☐ GI: Hemorrhoids
- ☐ GI: Incontinence
- ☐ GI: Inflammatory bowel disease
- ☐ GI: Irritable bowel syndrome
- ☐ GI: Liver Disease: Auto-Immune Hepatitis
- ☐ GI: Liver Disease - Hepatitis
- ☐ GI: Liver Disease - Hepatitis A
- ☐ GI: Liver Disease - Hepatitis B
- ☐ GI: Liver Disease - Hepatitis C
- ☐ GI: Liver Disease - Cirrhosis
- ☐ GI: Liver Disease: Sclerosing Cholangitis
- ☐ GI: Reflux/GERD
- ☐ GI: Other_____

UROLOGY

- ☐ Uro: Benign prostatic hypertrophy (large prostate)
- ☐ Uro: End stage renal disease (kidney failure)
- ☐ Uro: Incontinence
- ☐ Uro: Kidney Stones
- ☐ Uro: Recurrent urinary tract infections
- ☐ Uro: Urinary/kidney reflux
- ☐ Uro: Other_____

OB/GYN

- ☐ Ob/Gyn: Endometriosis
- ☐ Ob/Gyn: Fibroids
- ☐ Ob/Gyn: HPV (Papilloma virus/warts)
- ☐ Ob/Gyn: Polycystic ovary disease
- ☐ Ob/Gyn: Pregnancy history
- ☐ Ob/Gyn: Other

IMMUNO

- ☐ Immuno: HIV
- ☐ Immuno: Immunodeficiency
- ☐ Immuno: Other_____

LYMPH

- ☐ Lymph: Anemia
- ☐ Lymph: Bleeding disorder/Hemophilia
- ☐ Lymph: Blood clotting disorder
- ☐ Lymph: Neutropenia (low white blood count)
- ☐ Lymph: Sickle cell anemia
- ☐ Lymph: Thrombocytopenia (low platelets)
- ☐ Lymph: Other_____

ORTHO

- ☐ Ortho: Arthritis
- ☐ Ortho: Degenerative joint disease
- ☐ Ortho: Osteoporosis
- ☐ Ortho: Spinal stenosis
- ☐ Ortho: Other _____

NEURO

- ☐ Neuro: ALS
- ☐ Neuro: Alzheimer's
- ☐ Neuro: Autism
- ☐ Neuro: Cerebral (brain) aneurysm
- ☐ Neuro: Cerebral palsy
- ☐ Neuro: CVA/Stroke
- ☐ Neuro: Dementia
- ☐ Neuro: Developmental delay
- ☐ Neuro: Headaches Cluster
- ☐ Neuro: Headaches Migraine
- ☐ Neuro: Headaches Muscular Tension
- ☐ Neuro: Headaches (specify type)
- ☐ Neuro: MS (Multiple sclerosis)
- ☐ Neuro: Parkinson's
- ☐ Neuro: Seizures
- ☐ Neuro: Other_____

OPHTH/OPT

- ☐ Ophth/Opt: Blindness
- ☐ Ophth/Opt: Macular degeneration
- ☐ Ophth/Opt: Cataracts
- ☐ Ophth/Opt: Glaucoma
- ☐ Ophth/Opt: Detached retina
- ☐ Ophth/Opt: Other_____

PSYCH

- ☐ Psych: Anxiety
- ☐ Psych: Bipolar disorder
- ☐ Psych: Depression
- ☐ Psych: Personality Disorder
- ☐ Psych: Psychosis
- ☐ Psych: Schizophrenia
- ☐ Psych: Other_____

PULMONARY

- ☐ Pulm: Asthma
- ☐ Pulm: Bronchiectasis
- ☐ Pulm: COPD
- ☐ Pulm: Cystic Fibrosis
- ☐ Pulm: Emphysema
- ☐ Pulm: Obstructive sleep apnea (OSA)
- ☐ Pulm: Pulmonary Embolism
- ☐ Pulm: Pulmonary Fibrosis
- ☐ Pulm: Pulmonary Hypertension
- ☐ Pulm: Other_____

RHEUM

- ☐ Rheum: Autoimmune disorder (specify type)
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Gout
- ☐ Rheum: Lupus
- ☐ Rheum: Rheumatoid Arthritis
- ☐ Rheum: Scleroderma
- ☐ Rheum: Sjorgren's syndrome
- ☐ Rheum: Other_____

VASCULAR

- ☐ Vasc: Peripheral artery disease
- ☐ Vasc: Carotid stenosis

- ☐ Vasc: Abdominal aortic aneurysm
- ☐ Vasc: Thoracic aortic aneurysm
- ☐ Vasc: Other_____

OTHER

- ☐ Other_____

SURGICAL HISTORY *Please tell us about your surgical history. Check all that apply:*

ABDOMINAL/GI

- ☐ Abdominal/GI: Abdominoperineal resections (APR)
- ☐ Abdominal/GI: Appendectomy
- ☐ Abdominal/GI: Bariatric surgery (specify type)
- ☐ Abdominal/GI: Bowel resection
- ☐ Abdominal/GI: Cholecystectomy (gallbladder)
- ☐ Abdominal/GI: Colectomy - Colon resection
- ☐ Abdominal/GI: Colectomy - Diverticulitis
- ☐ Abdominal/GI: Colectomy - Inflammatory bowel disease
- ☐ Abdominal/GI: Colostomy
- ☐ Abdominal/GI: Esophagectomy
- ☐ Abdominal/GI: Exploratory bowel surgery
- ☐ Abdominal/GI: Gastrectomy (stomach resection)
- ☐ Abdominal/GI: Hepatectomy (liver resection)
- ☐ Abdominal/GI: Hemorrhoidectomy
- ☐ Abdominal/GI: Hernia repair
- ☐ Abdominal/GI: Liver Shunt
- ☐ Abdominal/GI: Liver transplant
- ☐ Abdominal/GI: Low anterior resection
- ☐ Abdominal/GI: Pancreas resection
- ☐ Abdominal/GI: Splenectomy
- ☐ Abdominal/GI: Other_____

BREAST

- ☐ Describe: _____

COSMETIC

- ☐ Describe: _____

HEART

- ☐ Describe: _____

LYMPH

- ☐ Describe: _____

NEUROSURGERY

- ☐ Describe: _____

OB/GYN

- ☐ Describe: _____

OPHTH/OPT

- ☐ Describe: _____

ORTHO

- ☐ Describe: _____

PULMONARY

- ☐ Describe: _____

SKIN

- ☐ Describe: _____

UROLOGY

- ☐ Describe: _____

VASCULAR

- ☐ Describe: _____

BREAST

- ☐ Describe: _____

COLON

- ☐ Describe: _____

EYE

- ☐ Describe: _____

KIDNEY

- ☐ Describe: _____

LIVER

- ☐ Describe: _____

OVARIES

- ☐ Describe: _____

PANCREAS

- ☐ Describe: _____

RECTUM

- ☐ Describe: _____

SPINE

- ☐ Describe: _____

UTERUS

- ☐ Describe: _____

OTHER

- ☐ Other: _____

ENT HISTORY

ENT Disease History Please check off any of the following conditions/ENT problems you have had in the past.

EAR

- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Hearing loss
- ☐ Ear: Mastoiditis
- ☐ Ear: Other_____
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Otosclerosis
- ☐ Ear: Tinnitus (ringing or other noise of the ear)
- ☐ Ear: Vertigo

GENERAL

- ☐ General: Facial fractures
- ☐ General: Other_____
- ☐ General: reflux

LARYNX

- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Subglottic stenosis
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord nodules
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord poly
- ☐ Larynx: Other_____

NASAL

- ☐ Nasal: Deviated septum
- ☐ Nasal: Epistaxis (nose bleeds)
- ☐ Nasal: Loss of smell
- ☐ Nasal: Nasal fracture
- ☐ Nasal: Nasal obstruction
- ☐ Nasal: Other
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Nasal: Turbinate hypertrophy

NECK

- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Hyperparathyroidism
- ☐ Neck: Neck mass
- ☐ Neck: Parotid tumor
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Sialolithiasis (stone of the salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules

ORAL

- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsillitis
- ☐ Oral: Ulcers
- ☐ Other_____

ENT Surgical History

Please check off any of the following **procedure(s)** you have had and provide date/year of procedure:

EAR

- ☐ Ear: Acoustic neuroma resection
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear)
- ☐ Ear: Other - specify _____
- ☐ Ear: Stapedectomy
- ☐ Ear: Repair ear drum

HEAD

- ☐ Head and neck: Lymph node biopsy
- ☐ Head and neck: Neck dissection
- ☐ Head and neck: Other - specify
- ☐ Head and neck: Parathyroidectomy
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Resection in mouth or throat - specify
- ☐ Head and neck: Skin graft
- ☐ Head and neck: Skin resection
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroidectomy

NOSE

- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other - specify
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction

THROAT

- ☐ Throat: Adenoidectomy
- ☐ Throat: Other - specify
- ☐ Throat: Sleep apnea surgery - uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other_____

MEDICATIONS

*Please list all medications you are **CURRENTLY** taking (not listed elsewhere):*

Medication	Dose/Frequency	Medication	Dose/Frequency
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____
7. _____	_____	8. _____	_____
9. _____	_____	10. _____	_____
11. _____	_____	12. _____	_____

Allergies to Prescription Medication

Please list all known prescription medication allergies as well as the type of reaction type and severity:

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

SOCIAL HISTORY

Smoking Status

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco Us

If applicable:

When did you start smoking? _____ Number of packs per day: _____

When did you quit smoking? _____ Total number of years smoking: _____

Alcohol Consumption

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day
- ☐ Other: _____

Employer & Occupation: _____

Place of Residence: _____

Family History *Please list any immediate (parent, siblings only) family history of illness or disease:*

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No