Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

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

PATIENT INFORMATION (ADULT)

Chart: ______________

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

Last Name | First Name | Middle Name | Suffix

Date of Birth ☐ male ☐ female | Marital Status | SS#

Street / Mailing Address | City | State | Zip Code

Home Phone (with Area Code) | Cell Phone (with Area Code) | Work Phone (with Area Code)

May we contact you via email? ☐ No ☐ Yes Email address: ______________________

Employer | Occupation

Employer's Street Address | City | State | Zip

Race: ☐ Native American/Alaskan ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Spouse or Emergency Contact | Relationship | Phone Number (with area code)

Insured Last Name | First Name | Middle Name

Date of Birth ☐ male ☐ female | Marital Status | SS#

Address | City | State | Zip Code

Cell Phone (with Area Code) | Work Phone (with Area Code)

Employer | Employer Address

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________

Referring Physician | Phone (with Area Code)

Family/Primary Physician | Phone (with Area Code)

Preferred Pharmacy | Location | Phone (with Area Code)

How did you hear about us? ☐ Physician referral ☐ TV/Online Ad ☐ Web Search ☐ Other ______________________

Payment of Fees: Necessary forms will be completed to help expedite insurance carrier payment to our office. 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 the insurance carrier 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 my copay, deductible, coinsurance and out of pocket maximums, as well as any services denied or not covered by my insurance company.

Signature ______________________________ **Date**________________

(If completing online you may submit unsigned form and then sign upon arrival)

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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.

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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.

- ☐ Chronic lung disease
- ☐ Asthma
- ☐ Recent Pneumonia
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Previous Stroke
- ☐ Gastric Ulcers
- ☐ Migraine Headaches
- ☐ Allergies
- ☐ Chronic Ear Infections
- ☐ Chronic Sinusitis
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Recent Dental Issues
- ☐ HIV

- ☐ Seizure Disorder
  Specify________________________
- ☐ Anesthesia Reaction
  Specify________________________
- ☐ Bleeding Disorder
  Specify________________________
- ☐ Cancer
  Specify________________________
- ☐ Heart Disease or heart attack
  Specify________________________
- ☐ Hepatitis
  Specify________________________
- ☐ Other
  Specify________________________
  ____
  ____

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).

□ Tonsillectomy
□ Adenoidectomy
□ Ear Tubes
□ Septoplasty
□ Thyroidectomy
□ Cholecystectomy
□ Appendectomy
□ Hysterectomy
□ Prostatectomy
□ Hemorrhoidectomy
□ Hernia Repair

□ Other Throat Surgery
Specify______________________
□ Neck Surgery
Specify______________________
□ Other Ear Surgery
Specify______________________
□ Previous Sinus Surgery
Specify______________________
□ Cardiac Procedures
Specify______________________
____
____

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

		Reaction
Penicillin	□ Yes □ No	Reaction: ______________________
Codeine	□ Yes □ No	Reaction: ______________________
Sulfa	□ Yes □ 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.

	Diabetes	Heart Disease	Hearing Loss	Thyroid Disease	Bleeding Disorder	Anesthesia Reaction	Cancer/Type	Other/Specify
Mother	Type 1 Type 2						__________	__________
Father	Type 1 Type 2						__________	__________
Sister	Type 1 Type 2						__________	__________
Brother	Type 1 Type 2						__________	__________
Aunt	Type 1 Type 2						__________	__________
Uncle	Type 1 Type 2						__________	__________
Maternal GM	Type 1 Type 2						__________	__________
Maternal GF	Type 1 Type 2						__________	__________
Paternal GM	Type 1 Type 2						__________	__________
Paternal GF	Type 1 Type 2						__________	__________