**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.

# PATIENT MEDICAL HISTORY

**Date** ____________

Name ______________________________ Age _________ DOB __________ Height _________ Weight __________

**1) Reason for todays visit:** ______________________________________________________________
______________________________________________________________

How long has this been present? ____ Days ____ Weeks ____ Months ____ Years
Previous episodes: ◻ Yes ◻ No When: ______________________________________________
Any medications taken or other doctors consulted? ______________________________________

**2) Illnesses**: Do you have or have you ever had any of the following? Check all that apply.

| | | | |
|---|---|---|---|
| ◻ Chronic lung disease | ◻ High Blood Pressure | ◻ Chronic Tonsillitis | ◻ Hepatitis |
| ◻ Asthma | ◻ Previous Stroke | ◻ Heart Disease | ◻ HIV |
| ◻ Recent Pneumonia | ◻ Gastric Ulcers | ◻ Heart Attack | ◻ Recent Dental Issues |
| ◻ Kidney Disease | ◻ Migraine Headaches | ◻ Chronic Sinusitis | ◻ Malignant Hypothermia |
| ◻ Diabetes: | ◻ Allergies | ◻ Thyroid Disease | ◻ Bleeding Disorder |
| ◻Type I ◻Type II | ◻ Chronic Ear Infections | ◻ Seizure Disorder | ◻ Cancer (describe): ____________________ |

**3) Surgeries**: Have you ever had any of these surgeries? Check all that apply.

| | | | |
|---|---|---|---|
| ◻ Tonsillectomy | ◻ Endoscopic Sinus Surgery | ◻ Appendectomy | ◻ Cesarean Section |
| ◻ Adenoidectomy | ◻ Balloon Sinuplasty | ◻ Hysterectomy | ◻ Hemorrhoidectomy |
| ◻ Ear Tubes | ◻Thyroidectomy | ◻ Hernia Repair | ◻ Pacemaker |
| ◻ Septoplasty | ◻ Cholecystectomy | ◻ Prostatectomy | ◻ Heart Stent |

Please list ANY other surgeries (including all cardiac, general, orthopedic, etc AND previous ear, nose, neck or throat surgeries):______________________________________________________________
______________________________________________________________

**4) Medications**: Please list prescription medications being taken OR provide a medication list.

| Medication | Strength | Medication | Strength |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you take aspirin or fish oil? ◻ Yes ◻ No Specify: ______________________________________
Does your religion prohibit you from receiving blood products or transfusions? ◻ Yes ◻ No

**5) Allergies to medications, tape, latex or iodine**:
Drug: ______________________ Reaction: ______________________
Drug: ______________________ Reaction: ______________________
Drug: ______________________ Reaction: ______________________

**6) Other Physicians:** Do you see any other specialists (i.e. Neurologist, Pulmonologist, Gastroenterologist, etc)?
Cardiologist: ◻ Yes ◻ No Name: ______________________________
Specialty: ______________ Name: ______________________________
Specialty: ______________ Name: ______________________________

**7) Social History**:

| Smoking Status | Alcohol Status | Recreational Drugs |
|---|---|---|
| ◻ Current, PPD: _________ | ◻ Currently | ◻ Currently, Type: _____________ |
| ◻ Former, Yrs: ___________ | ◻ Socially | ◻ Previously, Type: ____________ |
| ◻ Never | ◻ Occasionally / Rare | ◻ Never |
| | ◻ Never | |

**8) Family History:** Please list any significant family history, including the family member relation (i.e. mother, brother, paternal grandfather, etc) and disease. ______________________________________________
______________________________________________________________