CAREPOINTE EAR, NOSE, THROAT & SINUS CENTER

DATE _____

PATIENT INFORMATION - CHILD

LAST NAME	FIRST NAME	MIDDLE INITIAL	HOME PHONE #
STREET ADDRESS	CITY	STATE/ZIP CODE	CELL PHONE #
DATE OF BIRTH	SOCIAL SECURITY #	SEX ___MALE ___FEMALE	EMAIL ADDRESS
EMERGENCY CONTACT - NAME/PHONE #		HAS ANYONE IN YOUR HOUSEHOLD BEEN A PATIENT? ___YES ___NO RELATION	

PATIENT INFORMATION - FATHER

LAST NAME	FIRST NAME	CELL # / PHONE #	DATE OF BIRTH
ADDRESS IF DIFFERENT	EMPLOYER NAME / PHONE #		SOCIAL SECURITY #

PATIENT INFORMATION - MOTHER

LAST NAME	FIRST NAME	CELL # / PHONE #	DATE OF BIRTH
ADDRESS IF DIFFERENT	EMPLOYER NAME / PHONE #		SOCIAL SECURITY #

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	POLICY ID #	POLICY GROUP #
SUBSCRIBER NAME	SUBSCRIBER ADDRESS	DATE OF BIRTH
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	POLICY ID #	POLICY GROUP #
SUBSCRIBER NAME	SUBSCRIBER ADDRESS	DATE OF BIRTH
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

REFERRAL INFORMATION

REFERRED BY	ADDRESS	CELL / PHONE #
FAMILY PHYSICIAN	ADDRESS	PHONE #

I AUTHORIZE THE FOLLOWING PEOPLE TO ACCOMPANY MY CHILD TO HIS OR HER APPOINTMENT IN MY ABSENCE:

NAME / RELATION: _____ NAME / RELATION: _____

NAME / RELATION: _____ NAME / RELATION: _____

PARENT SIGNATURE: _____ RELATION TO PATIENT: _____

*** **PLEASE NOTE, IF YOU ARE NOT THE MINOR PATIENTS PARENT, YOU MUST ATTACH PROOF OF GUARDIANSHIP***

Consent to Share Confidential Medical/Billing Information

Patient's Legal Name: _____ Patient's Date of Birth: _____

I HEREBY AUTHORIZE CAREPOINTE EAR, NOSE, THROAT & SINUS CENTERS TO SHARE ANY RELAVENT MEDICAL INFORMATION REGARDING THE ABOVE NAMED PATIENT INCLUDING BUT NOT LIMITED TO INFORMATION ABOUT APPOINTMENT TIME, DATE AND REASON FOR VISIT, BILLING INFORMATION, MEDICATIONS AND MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

FULL NAME _____ **RELATIONSHIP** _____

FULL NAME _____ **RELATIONSHIP** _____

FULL NAME _____ **RELATIONSHIP** _____

I understand that I may cancel this consent at any time in writing to CarePointe Ear, Nose, Throat and Sinus Center, but that cancelling it will not affect any information that has already been released.

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____
(If patient is a minor)

Financial Policy

Please initial each line and sign below

_____ **I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statement, promptly upon presentment, unless credit arrangements are made prior with the billing department.**

_____ **I hereby authorize the assignment of any insurance benefits and agree to be liable for any remaining balance not paid by insurance or other benefits. In addition to the remaining balance, I agree to pay all collection costs and reasonable fees in the event the delinquent account is turned over to our attorneys or collection agency.**

_____ **I authorize transfer of all above information to Southlake Speech and Hearing Center. (In the event audiological services are needed)**

_____ **I authorize the release of any medical or other information necessary to process claims.**

_____ **I authorize CarePointe to communicate appointment reminders and general messages through all provided points of contact, which may include U.S. mailing addresses, e-mail addresses and/or telephone numbers/voicemail.**

_____ **I understand that I will be charged a $25 missed appointment/no-show fee if I do not give 24 hours advanced notice of cancellation.**

_____ **I have been given the opportunity to review CarePointe's financial policy and I agree to abide by it's guidelines.**

_____ _____ _____

DATE **SIGNATURE OF RESPONSIBLE PARTY** **RELATION TO PATIENT**

CAREPOINTE HEALTH HISTORY

Date: _____

Dear valued Patient,
To comply with Government standards and improve our record keeping, it is important that you fill out this form as completely as possible so that we may gather information in a more meaningful way for your treatment and care.

Patient's Last Name _____ **First** _____ **MI** _____

Sex: ☐ **Male** ☐ **Female** **Height** _____ **Weight** _____ **DOB** _____ **Occupation** _____

Pharmacy Preference (include location/phone) _____

Name of Primary Care Physician _____

Name of Physician referring you today _____

Approximate date (MO/YR) of last Influenza Vaccine _____ **Declined Vaccine** ☐ **Never Received Vaccine** ☐

Approximate date (MO/YR) of last Pneumonia Vaccine _____ **Declined Vaccine** ☐ **Never Received Vaccine** ☐

Approximate date (MO/YR) of last Colonoscopy _____ **Declined Colonoscopy** ☐ **Never Received Colonoscopy** ☐

Approximate date (MO/YR) of last Mammogram _____ **Declined Mammogram** ☐ **Never Received Mammogram** ☐

Approximate date (MO/YR) of last Pap Smear _____ **Declined Pap Smear** ☐ **Never Received Pap Smear** ☐

REASON FOR TODAY'S VISIT _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

Add Additional Medicines on back

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ **Yes** ☐ **No** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If yes, please list type of problems _____

List any surgeries you have had (including dates) _____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ Yes ☐ No
If yes, list reasons for hospitalizations _____

_____