Jeffrey M. Braaten, D.O.
Gary D. Goodnight, D.O.
Taylor R. Tidmore, M.D.
Christopher Thompson, M.D.
Jason L. Acevedo, M.D.
Paula Parkhill, FNP-BC

Ear, Nose & Throat Specialists of Abilene

1233 N. 18th Street • Abilene, TX 79601
(325) 437-3687 • Fax (325) 437-3873

PLEASE PRINT ALL INFORMATION

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

PATIENT'S NAME: _____ D.O.B.: _____ AGE: _____ SEX: _____

SOCIAL SECURITY #: _____ E-MAIL: _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): _____

NAME OF PERSON(S) RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT): _____

MAILING ADDRESS: _____ APT.: _____

CITY, STATE, ZIP: _____ HOME PHONE: (_____) _____

BUSINESS PHONE: (_____) _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE PARENT / SPOUSE: (_____) _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

FINANCIALLY RESPONSIBLE PERSON(S):

DRIVER'S LICENSE #: _____ STATE: _____ WE WILL ASK TO MAKE A COPY OF YOUR LICENSE

PRIMARY INSURANCE: _____ 2ND INS. _____

NAME OF INSURED: _____ D.O.B.: _____ S.S.#: _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? ☐ YES ☐ NO

MAY WE LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? ☐ YES ☐ NO

PLEASE LIST PERSONS WITH WHOM WE CAN DISCUSS YOUR MEDICAL INFORMATION:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____) _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

OTHER PHYSICIANS TREATING YOU: _____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO REFERRING DOCTOR AND/OR ANY DOCTOR TO WHOM DRS. BRAATEN, TIDMORE, OR GOODNIGHT MAY REFER ME. I AUTHORIZE MY FAMILY OR REFERRING DOCTOR TO RELEASE MY RECORDS TO DRS. BRAATEN, TIDMORE, OR GOODNIGHT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENTS OF INSURANCE BENEFITS BE MADE TO **ENT SPECIALISTS OF ABILENE**. I HEREBY AFFIRM THAT ALL INFORMATION PROVIDED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND WILL ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT WITH **ENT SPECIALISTS OF ABILENE**.

AUTHORIZED SIGNATURE: _____ S.S. #: _____ D.O.B.: _____

RELATIONSHIP TO PATIENT: _____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. ***Please fill out every item.*** *It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.*

FULL NAME: _____ DATE OF BIRTH: _____

☐ MALE ☐ FEMALE HEIGHT: _____FT. _____IN. WEIGHT: _____LBS.

PHARMACY PREFERENCE (include location): _____

CURRENT MEDICATIONS

ARE YOU TAKING **ANY** KIND OF MEDICATION NOW? (include prescription, over-the-counter and herbal medications) ☐ NO ☐ YES

IF YES, PLEASE LIST BELOW. **INCLUDE DOSAGES.**

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

KNOWN ALLERGIES

ARE YOU ALLERGIC TO **ANY** MEDICATIONS, SOAPS, LAUNDRY DETERGENTS, FOODS, ETC.? ☐ NO ☐ YES

IF YES, PLEASE LIST BELOW.

NAME OF MEDICATION, FOOD OR PRODUCT	TYPE OF REACTION

HAVE YOU HAD PROBLEMS WITH ANESTHESIA (BEING NUMBED OR PUT TO SLEEP)? ☐ HIGH FEVER ☐ TROUBLE WITH INTUBATION (placement of breathing tube)

HAVE YOU HAD SURGERY? ☐ NO ☐ YES

IF YES, LIST TYPES AND WHEN THEY WERE DONE: _____

_____

_____

PREVIOUS OR OTHER MEDICAL PROBLEMS: _____

_____

SOCIAL HISTORY

WHAT IS OR WAS YOUR OCCUPATION? _____

WHAT IS THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY? _____

_____

Ear, Nose & Throat Specialists of Abilene

OTOLARYNGOLOGY • HEAD & NECK SURGERY (ENT) • ALLERGY • AUDIOLOGY

JEFFREY BRAATEN, D.O. TAYLOR R. TIDMORE, M.D. GARY D. GOODNIGHT, D.O.

CHRISTOPHER THOMPSON, M.D. JASON L. ACEVEDO, M.D.

Assignment of Benefits Form

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms with be completed to file for insurance carrier payments.

I have requested medical services from **ENT Specialists of Abilene, LLP**, on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to **ENT Specialists of Abilene, LLP,** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient Consent for Disclosure of Information: I have read the Notice of Privacy Practices and have had any questions answered by this office. I understand that by signing this form, I consent to the following:

(a) Sharing information for purposes of treatment; this includes sharing this information with all members of my treatment team, both within and outside of this office (examples: laboratory services, radiology, primary care physicians, hospitals, etc...);

(b) Sharing information for purposes of payment: includes all necessary information to process insurance claims generated in the course of examination or treatment. This includes both governmental payers and non-governmental payers and includes any representatives appointed by the insurance carriers for purposes of benefit determination, utilization review and billing; I also consent to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

(c) Sharing of information for purposes of operations; this includes all ongoing operations of this office including, but not limited to, credentialing, peer review, accreditation and compliance with federal and state laws.

My consent is freely given. I understand that I may revoke this assignment and consent at any time if that revocation is in writing, but any disclosures given in reliance of this prior consent will be permissible.

I have read and understand the financial policy on the reverse side of this page and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

PATIENT NAME PRINTED

_____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY IF MINOR DATE

_____ _____

WITNESS DATE

CONLEY PRINTING #9660

Ear, Nose & Throat Specialists of Abilene

OTOLARYNGOLOGY • HEAD & NECK SURGERY (ENT) • ALLERGY • AUDIOLOGY
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Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Practice Administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Office Visits -

- If you do not have insurance, payment is due at time of service. Uninsured new patients are required to pay $80.00 at the time of the first visit, which will be collected when you arrive for your appointment.
- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. **It is the policy of our office to collect this co-payment when you arrive for your appointment.**
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will file with your insurance on assigned basis. However, you will be fully responsible for any amount that your insurance does not pay.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Surgical Services -

- We will bill your health plan for all surgical services. We will verify coverage and benefits and obtain any required prior authorization prior to your surgery. You are expected to pay your remaining deductible and your estimated co-payment prior to surgery. If you cannot pay the full amount, you must make payment arrangements with the Practice Administrator prior to the pre-operative visit. Any balance due after insurance payment is your responsibility and is due upon receipt of a statement from our office.
- If you do not have insurance, you must make financial arrangements with our Practice Administrator prior to your pre-operative visit.

Allergy Services -

The practice will accept assignment on allergy services. However, the manner in which insurance claims for allergy services are paid varies greatly from company to company and policy to policy. Prior to beginning allergy treatment, please arrange to speak with the Billing Supervisor or the Practice Administrator regarding what to expect financially. **You are responsible for any amount that your insurance company does not pay, subject to managed care contract rules.** If the account is not kept current, allergy treatment is subject to suspension.

Minor Patients -

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

CONLEY PRINTING #9660

ENT Specialists of Abilene

Name: _____ ***Date of birth:***

1) Have you been diagnosed with a heart condition? YES / NO
   If yes, please list below...
   _____
   _____

2) Do you take any blood thinners? (ex. Aspirin, Xarelto, Coumadin, Warfarin) YES / NO
   If yes, please list below...
   _____
   _____
   _____

3) Have you been diagnosed with diabetes? YES / NO

4) Do you have a personal or family history of malignant hypothermia? YES / NO
   If yes, please specify relation below...
   _____
   _____
   _____

5) Have you been diagnosed with asthma or COPD? YES / NO
   If yes, please specify which...
   _____
   _____
   _____

6) Have you been diagnosed with any bleeding disorders? YES / NO
   If yes, please specify which...
   _____
   _____
   _____

7) Have you been diagnosed with any Kidney disorders? YES / NO
   If yes, please list below...
   _____
   _____
   _____

8) Have you been diagnosed with epilepsy? YES / NO

9) Have you received or are you currently receiving chemotherapy or radiation therapy? YES / NO

10) Please list any physicians treating these conditions. Please specify the physician's specialty.
   _____
   _____