Jeffrey M. Braaten, D.O.
Gary D. Goodnight, D.O.
Taylor R. Tidmore, M.D.
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1233 N. 18th Street
Abilene, TX 79601
(325) 437-3687
Fax (325) 437-3873

Arrival Time: ____________

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:

	NAME	PHONE	RELATIONSHIP TO PT	EXPIRATION DATE (IF ANY)
1.				
2.				
3.				

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 ENT SPECIALISTS OF ABILENE MAY REFER ME. I AUTHORIZE MY FAMILY OR REFERRING DOCTOR TO RELEASE MY RECORDS TO ENT SPECIALISTS OF ABILENE. 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: ____________

CONLEY PRINTING REORDER #9469

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: ______________________________

____

____

____

____

____

CONLEY PRINTING REORDER #9469

Patient Name:_________________________________ **DOB:**______________________

Do you have or have you ever had the following (Mark all that apply):

ENT History

__None
__Acute Otitis Externa
__Acute Otitis Media
__Allergic Rhinitis
__Basal Cell Carcinoma of skin
__Cholesteatoma
__Deviated nasal septum
__Enlargement of tonsil of adenoid
__Fractured nasal bones
__Gastroesophageal reflux disease
__History of hearing loss
__Hyperparathyroidism
__Loss of sense of smell
__Malignant Neoplasm of skin
__Mass of neck
__Mastoiditis
__Nasal obstruction
__Polyp of nasal sinus
__Polyp of vocal cord
__Sinusitis
__Sleep apnea
__Squamous cell carcinoma of skin
__Suspected head and neck cancer
__Thyroid nodule
__Tinnitus
__Tonsillitis
__Vertigo
Other ___________________________

ENT Family History

Does anyone in your family have below:

__None
__Otitis Media (Middle Ear Infection)
__Sinusitis

ENT Pediatric History

__None
__Cleft Lip
__Cleft Palate

ENT Surgical History

__None
__Adenoid excision
__Endoscopic balloon dilation
__Functional endoscopic sinus surgery
__Tonsillectomy
__Myringotomy & insertion of tympanic Ventilation tube
__Nasal septoplasty
__Operation on nose
__Parathyroidectomy
__ Reduction of nasal turbinate
__Thyroidectomy
Other:_________________________

Past Surgeries

Have you had any of he following surgeries or procedures?

__None
__Biopsy of lymph node
__Biopsy of skin
__Blepharoplasty
__Carotid Endarterectomy
__Cardiac catheterization
__Rhinoplasty
__Coronary angioplasty
__Excision of basal cell carcinoma
__Excision of lymph node
__Excision of squamous cell carcinoma
__Bariatric surgical procedure
__Colectomy
__Mechanical heart valve replacement
__ Nephrectomy
__Implantation of cardiac pacemaker
__Open heart surgery

Other:_____________
____
____

Past Medical Conditions

__Age related macular degeneration
__Aortic aneurysm
__Arthritis
__Asthma
__Autistic disorder
__Autoimmune disease
__Barrett's esophagus
__Carotid artery stenosis
__Chronic obstructive lung disease
__Congestive heart failure
__Cystic fibrosis
__Dementia
__Disease caused by 2019-nCoV
__Disorder of immune function
__Disorder of thyroid gland
__Esophageal reflux
__Malignant melanoma
__Atrial fibrillation
__Depression

__Diabetes Mellitus
__Hypertension
__Cerebrovascular accident
__Cardiac Catheterization
__Diabetes Mellitus type 2
__Leukemia
__Malignant basal cell neoplasm of skin
__Malignant Lymphoma
__Renal failure
__squamous cell carcinoma of skin
__Human immunodeficiency virus infection
__Hypercoagulability state
__Kidney stone
__Migraine
__Myocardial infarction
__Obstructive sleep apnea
__Pituitary adenoma
__Pulmonary embolism

__Prenancy
__Headache disorder
__Sjogren's syndrome
Other:__________

Social History

Smoking Habits

What is your smoking status? (QM402,QM226)

__Unknown if ever smoked __Current every day smoker __Current smoker – Tobacco
__Current smoker-Cigarettes __Former Smoker __Never smoker __Cigar smoker

Alcohol and Drug Use

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (QM431) Enter Number__________
Do you consume alcohol (EtOH or grain alcohol)? Y / N
Recreational Drug Use? Y / N

Driving Status

Drive in the Daytime? Y / N
Drive at Night? Y / N

Exercise Status

How often do you exercise? __________

Caffeine Usage

Do you drink caffeinated drinks? Y / N
If so, How many per day? __________

Occupation

What is your occupation and workplace?
____

Residence Status

What is your place of residence?
Do you feel safe at your place of residence? Y / N

ENT 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.

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 $150.00 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

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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