REGISTRATION FORM

PATIENT MUST BE ACCOMPANIED BY AN ADULT IF UNDER 18

PATIENT INFORMATION:

Please print clearly Confidential Patient Information *Today's Date:* ______________________

Legal Name: ____________________________ *Age:* _____ *Birth Date:* __________ *Sex: M F*

Social Security #: ____________________________ *Marital Status: S M W D Separated*

Tx. Drivers License: ______________________

Address: ____________________________ *City:* ______________ *State:* ____ *Zip:* ____________

Home Phone: ____________________________ *Cell Phone:* ______________________________

Employer: ____________________________ *Work Phone:* ______________________________

E-Mail Address: ____

RESPONSIBLE PARTY INFORMATION: *(policy holder)*

Legal Name: ____________________________ *Age:* _____ *Birth Date:* __________ *Sex: M F*

Social Security #: ____________________________ *Marital Status: S M W D Separated*

Tx. Drivers License: ______________________

Address: ____________________________ *City:* ______________ *State:* ____ *Zip:* ____________

Home Phone: ____________________________ *Cell Phone:* ______________________________

Employer: ____________________________ *Work Phone:* ______________________________

E-Mail Address: ____

SPOUSE OR SECOND PARENT INFORMATION:

Legal Name: ____________________________ *Age:* _____ *Birth Date:* __________ *Sex: M F*

Social Security #: ____________________________ *Marital Status: S M W D Separated*

Address: ____________________________ *City:* ______________ *State:* ____ *Zip:* ____________

Home Phone: ____________________________ *Cell Phone:* ______________________________

Employer: ____________________________ *Work Phone:* ______________________________

E-Mail Address: ____

NEAREST RELATIVE INFORMATION:

Legal Name: ____________________

Address: ____________________ *City:* ____________________ *State:* ______ *Zip:* ________

Home Phone: ____________________ *Work Phone:* ____________________

INSURANCE INFORMATION:

Primary Insurance Co.: ____________________ *I.D. #* ____________________

Employer Group Name: ____________________ *Group #:* ____________________

Insurance Claims Address: ____________________

Insurance Phone #: ____________________

Subscriber's Name: ____________________ *Relation to Patient:* ____________

Place of Employment: ____________________

Secondary Insurance Co.: ____________________ *I.D. #* ____________________

Employer Group Name: ____________________ *Group #:* ____________________

Insurance Claims Address: ____________________

Insurance Phone #: ____________________

Subscriber's Name: ____________________ *Relation to Patient:* ____________

Place of Employment: ____________________

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS INCLUDING MEDICARE SO THAT WE MAY MAKE A COPY FOR YOUR FILE.

- ***Authorization to release information and assign benefits:***
- ***I hereby authorize the release of any medical information in the processing of my claim. I also authorize payment directly to Dr. Peters, Dr. Hahn and Dr. Dansby for the medical / surgical benefits.***

Signed: ____________________ **Date:** ____________

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

____________________ ____________________

Name of Minor **Signature of Parent/Guardian**

Health History Questionnaire

Date: ___________________

Name: ____ **Age:** ________ **DOB:** ____/______ /_______

Occupation: ____ ☐ Male ☐ Female

Referring Physician: ____

Primary Care Physician: ____

Chief Complaint: What symptoms are you having that brings you to this visit.

____

Medications: Name Amount How Often

____

____

____

____

____

Allergies: Are you allergic to any medications? Yes No
If so, which ones: ____

Past History:

General	None	Wt Change / Fatigue / Difficulty Walking
Eyes	None	Glaucoma / Cataracts / Double Vision
Heart	None	High Cholesterol / Hypertension / Heart Attack / Cardiac Disease
Lung	None	Asthma / Snoring / Sleep Apnea / COPD
GI	None	Ulcers / Reflux Disease / Hepatitis
Kidney	None	Stones / Renal Failure / Prostate / UTI
Musculo Skeletal	None	Arthritis / Fractures / Weakness / TMJ
Endocrine	None	Thyroid / Diabetes
Neuro	None	Migraines / Head Trauma / Stroke / Multiple Sclerosis
Immuno	None	Seasonal Allergies / Autoimmune / Sinusitis / HIV
Psych	None	Depression / Anxiety / Psychosis
Other History		

Past Surgical History:

Have you ever had ear surgery? Yes No

If yes, what type: ____________________

Have you ever had any other type of surgery? Yes No

If yes, what type: ____________________

Present Problem:

	Rt Ear	**Lt Ear**	**Duration**
Hearing loss	______	______	______
Fluctuating Hearing	______	______	______
Ear Fullness	______	______	______
Ringing / Tinnitus	______	______	______
Ear Infection	______	______	______
Better Hearing Ear	______	______	______
Hearing Aid	______	______	______
Ear Pain	______	______	______

Do you have dizziness Yes No (if no, skip this section)

If yes, When did it begin? ____________________
How long does it last? ____________________
How often does it happen? ____________________
Is your dizziness: ____ Mild ____ Moderate ____ Severe
Does your dizziness affect your work? ____ Yes ____ No
Does your dizziness affect your Driving? ____ Yes ____ No
Describe your Dizziness:
Spinning / Vertigo ____ Yes ____ No
Lightheadedness ____ Yes ____ No
Off Balance ____ Yes ____ No
Positional ____ Yes ____ No
Nausea ____ Yes ____ No
Headache ____ Yes ____ No

Family History: What medical problems run in your family? *including ear problems*

Father: ____________________
Mother: ____________________
Other: ____________________

Social History:

Noise Exposure ____________________
Do you smoke? Yes No How many cigarettes per day? __________
Do you drink alcohol? Yes No If yes, ___occasional ___moderate ___ frequent
Do you drink caffeine? Yes No

I acknowledge that the information stated above is true and complete:

______________________________ ______________
Patient / Guardian Signature Date

______________________________ ______________
Reviewing Physician Signature Date

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign prior to any treatment. Dr. Peters, Dr. Hahn and Dr. Dansby render only services that, in their best professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE
We accept cash, checks, Visa or MasterCard

REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

- *The patient is responsible to pay any deductible and co-payments at the time services are rendered.*
- *It is your responsibility to know if a referral is necessary for your visit.*
- *Any portion of a billed amount that is labeled "disallowed" or "not covered" will become the patient's responsibility.*
- *Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.*
- *Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. While we have an agreement with the Health Plan to provide services, any questions regarding coverage must be resolved by you with the insurance company.*
- *Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.

NSF CHECKS

All returned checks will be assessed a $36.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

____

Signature of patient or person responsible for the bill *Date*

Notice of Privacy Practices
Acknowledgement Form

I acknowledge receipt of this Notice of Privacy Practices which I have reviewed and give my permission to Dallas Ear Institute to use and disclose my health information in accordance with it.

________________________	________________________
Signature of Patient	Signature of Patient's Representative (if applicable)
Name of Patient (print)	Relationship of Representative to Patient (if applicable)
Date	Date