Lake Jackson
Ear, Nose and Throat

Patient Information

Today's Date

Last Name | First Name | Middle initial | Nickname / AKA

Date of Birth | Social Security Number | Gender

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Marital Status

Employer

Home Address | Apt # | City | State | Zip

☐ Home Phone ☐ Work Phone ☐ Cellphone
Please mark and fill in you preferred primary phone

Email Address ☐ Permission to communicate by email

Responsible Party / Guarantor Information

Who is the responsible party / guarantor? ☐ Self / Patient ☐ Other (complete below)

Last Name | First Name | Middle initial | Date of Birth

Home Address | Apt # | City | State | Zip

☐ Home Phone ☐ Work Phone ☐ Cellphone Email Address

Relationship to Patient | Divers License # & State (required)

Emergency Contact | **Phone**

Physician Referral Information

Primary Care Physician Name | Primary Care Physician Phone #

Referring Care Physician Name | Referring Care Physician Phone #

Pharmacy Information

Pharmacy Name | Pharmacy Address | Pharmacy Phone # | Pharmacy Fax #

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Patient Insurance Form

Note: Please make sure you provide us a copy of each insurance card. if your insurance changes, please let us know so we can update your records.

Patient Information

Last Name | First Name | Middle initial | Nickname / AKA

First (Primary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Second (Secondary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Assignment Of Benefits: I hereby assign all medical benefits to which I might be entitled, including Medicare, Medicaid, Private Insurance or Worker's Compensation (this list is not all inclusive) to Stephanie Herrera, MD and Associates, PA for services provided to myself and/or my dependents and not yet paid in full. I hereby authorize and direct my insurance carrier to issue payment directly to the provider listed. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient/Legal Guardian | Date

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Authorization to Treat a Minor Patient

In the event that a parent or legal guardian is unable to accompany the child to an appointment, you may use this form to give another adult permission to bring your child to their visit(s). You further acknowledge you have the authority to consent and designate medical treatment for the child and this will be relied on by the provider.

Pursuant to Sections 32.001 and 32.002 of the Texas Family Code,

I/we, ____________________ (name of parent/guardian) and ____________________ (name of parent/guardian), the parent(s) and legal guardian(s) of ____________________ (name of child),

hereby authorize ______________________ (name of adult accompanying child to office) to accompany the above-referenced child to office visits with

Stephanie Herrera, M.D., Rachel Jones, FNP-C, and/or Sarah Bennett, Au.D., CCC-A, and to consent to the examination and/or treatment of the child during the visit.

This authorization:

☐ is effective only on ____.

☐ is effective from __________________ to _______________________.

☐ is effective until revoked by me/us in writing.

I/we reserve the right to revoke this authorization at any time by writing to Stephanie Herrera, M.D., and Associates at 215 Oak Drive, Ste. F, Lake Jackson, Texas 77566.

I/we understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment of an authorized adult.

I/WE AGREE TO INDEMNIFY AND HOLD HARMLESS FROM ANY EXPENSE OR CLAIM OF ANY NATURE ANY ENTITY THAT PROVIDES OR CAUSES TO BE PROVIDED EXAMINATION, TREATMENT, OR HOSPITAL CARE UNDER THIS AUTHORIZATION AND CONDITIONALLY AGREE TO MAKE OR CAUSE TO BE MADE, BY ASSIGNMENT OF THIRD-PARTY BENEFITS OR OTHERWISE, FULL AND COMPLETE PAYMENT FOR SUCH EXAMINATION, TREATMENT, OR HOSPITAL CARE.

____
Signature of Parent/Guardian Date

____
Signature of Parent/Guardian Date

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Ear, Nose and Throat

Patient Consent Form

Please review the statements below and initial where indicated.

Last Name	First Name	Middle initial	Date of Birth

Consent to Evaluate and Treat

I authorize Lake Jackson ENT to evaluate and provide treatment for my otolaryngology needs, as well as those of my auditory system. This may include medical management of a variety of ear, nose and throat disorders; comprehensive audiometry threshold evaluation and speech recognition; tympanometry; acoustic reflex testing, and earmold impressions.

Initials __________

HIPAA Consent (copies of the law available upon request)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment and/or billing, or where applicable by law.

Initials __________

I give permission for Lake Jackson Ear, Nose & Throat to release upon request information (medical, financial and/or appointment) to the following individual(s):

Name of Person ______________________________ Relationship ______________________

Name of Person ______________________________ Relationship ______________________

Consent for Medical Photography

I agree to have photographs taken in the course of 1) pre-operative evaluation and planning; 2) intra-operative or procedural documentation or evaluation; or 3) post-operative documentation or evaluation. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Initials __________

Authorization to Include in Educational and/or Marketing Outreach

Authorizing marketing communication from this practice means I may:

A. Receive communication concerning treatment alternatives or other health-related products or services.

Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications from this Practice Only
- ☐ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates
- ☐ I **DO NOT** wish to receive **ANY** Marketing Communications

Initials __________

Your information will never be released or sold to any outside entity. Any other release of your Protected Health Information requires a signed HIPAA release form. You may opt out of future educational/marketing outreach by writing to us at:
215 Oak Drive South, Suite F, Lake Jackson, TX 77566

____ ____________________

Patient Signature Date

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Ear, Nose and Throat

Medical Health History

Name: ______________________ Date of Birth/Age: ______________ Date: ______________

Occupation: ______________________ Marital Status: ______________________

Referred by: ______________________ Primary Doctor: ______________________

Past Medical Problems: ____

____

____

Prior Surgeries: ____

____

____

Current Medications: ____

____

____

Allergies to Medications: ____

Social History: Smoking/Chew: Never ________ Current ________ Past ________ Secondhand ________

How much? ______________________ If quit, when? ______________________

Alcohol (including beer): Never ______________ Current ____________ Past ______________

How much? ______________________ How often? ______________________

Family Medical Problems:
Mark the box of each family member who has a history of the following medical problems:

Relationship	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Complications from Anesthesia								
Asthma								
Autoimmune Disease								
Bleeding/Clotting Problems								
Cancer								
Diabetes								
High Blood Pressure								
Hearing Problems								
Heart Attack								
Kidney Problems								
Liver Problems								
Lung Problems								
Seizures								
Stomach or Colon Problems								
Stroke								
Thyroid Problems								

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Review of Symptoms

Name: ________________________ Date of Birth/Age: ____________ Date: ______________

Review of Symptoms: Do you currently have any of the following symptoms? *(Circle all that apply)*

General: Fever Chills Night Sweats Fatigue Weight Loss Weight Gain Decreased Activity

Other: ________________________

Eye: Recent Vision Changes Double Vision Yellow Eyes Dry Eyes Excess Tearing

Other: ________________________

Ear/Nose/Throat: Hearing Loss Ringing in the Ears Dizziness Ear Pain Nasal Drainage Nasal Congestion Hoarse Voice Difficulty Swallowing

Other: ________________________

Respiratory: Shortness of Breath Wheezing Cough Apnea Snoring Loud Breathing

Other: ________________________

Cardiovascular: Chest Pain Irregular Heartbeat Swelling of the Legs Poor Circulation Fainting

Other: ________________________

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Yellow Skin Bleeding from Rectum

Other: ________________________

Genitourinary: Difficulty Urinating Blood in Urine Pain Urinating Frequent Urination Discharge Lesions

Other: ________________________

Hematology: Anemia Bruising Bleeding Easily Swollen Lymph Glands Prior Blood Transfusion

Other: ________________________

Endocrine: Excessive Thirst Cold Intolerance Heat Intolerance Hot Flashes High Blood Sugar Low Blood Sugar

Other: ________________________

Immunologic: Immunocompromise History of Cancer Treatment Recurrent Fevers Recurrent Infections

Other: ________________________

Musculoskeletal: Back Pain Joint Pain Muscle Weakness Muscle Cramp Joint Swelling Restless Leg

Other: ________________________

Skin: Lesions Rashes Itching Burns Hypertrophic Scarring Keloid Dryness

Other: ________________________

Breast: Lump Mass Nipple Discharge Pain

Other: ________________________

Neurological: Confusion Memory Loss Balance Problem Headache Fainting Numbness Weakness

Other: ________________________

Psych: Anxiety Depression Mania Suicidal Thoughts Hallucinations Sleeping Problems Anorexia

Other: ________________________

Any other symptoms not listed: ________________________