RED RIVER E.N.T. & ASSOC.

Patient Information Form

OFFICE USE ONLY
- ☐ **Paul A. Guillory, M.D.**
- ☐ **Renick P. Webb, M.D.**
- ☐ **Christian J. Wold, M.D.**

Date ____________________________

Patient Information Section (Please fill out *every single* line)

Name ____ Age ________ Date of Birth __________________ Race _________________
Last First Middle

Sex: ☐ male ☐ female Social Security # ____________________________ Drivers License # /State ____

Mailing Address ____ APT# _________ City / State / Zip_____________________________

Email ____Marital Status:_________________________________

Phone: Home # _____________________ Work # _____________________ other # _____________________ Employer ____________________________

Language:____________________________________ Ethnicity (please check one): ☐ Hispanic ☐Non-Hispanic ☐ Refused to Respond

Preferred Pharmacy Name: ___________________________________Pharm Phone #: _____________________ City/State:__________________________

Emergency Contact? (someone outside of the home) _____________________________ Phone # ___________________ Relationship _________________

RESPONSIBLE PERSON INFORMATION: ☐ Spouse | ☐ Mother | ☐ Father | ☐ Guardian

Name __________________________________ Social Security # ____________________ DOB ____________ Employer ____________________________

Address ____ Phone: work # ____________________ other # ______________________

PATIENT INSURANCE INFORMATION

Insured Party __________________________________ Employer __________________________________ Social Security# ________________________
(Name on Insurance Card)

Insured Party DOB:_____________________ Relationship to Patient______________________________________

I hereby instruct and direct ____ Insurance Company to pay by check made out and mailed to:

Paul A. Guillory, M.D. | Renick P. Webb, M.D. | Christian J. Wold, M.D.

Or if my current policy prohibits direct payment to my doctor and/or the service provider, I hereby also instruct and direct you to make the check to me and mail it as follows:

Paul A. Guillory, M.D. | Renick P. Webb, M.D. | Christian J. Wold, M.D.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on this form. I authorize my doctor and/or the service provider to initiate a compliant to the Insurance Commissioner for any reason on my behalf.

I understand and agree (that regardless of my insurance), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X_____________________________________ ________________________
Signature of Patient or Legal Representative Date

Name:___________________________________ Date of Birth:________________ Today's date:_____________

Home #:_______________________________ Work #:_____________________ Cell #: ___________________

(If patient is a minor)

Mother's name:___________________________________ Father's name: _____________________________

PATIENT Medical History: Please check all that apply to the _PATIENT._

☐ High Blood Pressure	☐ Lung Disease	☐ Thyroid Disease	☐ Blood Transfusion	☐ HIV
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis	☐ Malignant hypothermia	☐ Other
☐ Heart Disease	☐ Liver Disease	☐ Psychiatric disorder	☐ Cancer	

Explain all that are checked:____

____

List all current medications, including over the counter medications:_____________________________

____

Drug Allergies:____

____

Surgical History: List previous surgical procedures and date performed:___________________________

____

FAMILY History: Does any _FAMILY MEMBER_ have a history of:

☐ Cancer	☐ Hearing Loss	☐ Bleeding abnormalities
☐ Problems with Anesthesia or high fever with anesthesia		

Please explain all that are checked:____

____

Social History:

Do you	☐ Smoke	☐ Drink alcohol	☐ Use recreational drugs

Have you	☐ Had a history of tobacco use	☐ Incurred exposure to environmental tobacco smoke
	☐ Had a tobacco dependence	☐ Incurred occupational exposure to environmental tobacco smoke

If the patient is a minor child, does the parent/guardian smoke around the child? ___Yes ____No

Review of systems: Have you had a chronic problem with any of the following:

General	HEENT	Resp.	CV	GI
☐ Fever	☐ Ear Infections	☐ Bronchitis	☐ Chest pain	☐ Nausea
☐ Chills	☐ Hearing Loss	☐ Asthma	☐ Irreg. Heart Beat	☐ Vomiting
☐ Weight Loss	☐ Allergic Rhinitis	☐ Pneumonia	☐ Shortness of breath	☐ Bloody Stool
☐ Night sweats	☐ Nasal Congestion	☐ Coughing	☐ Circulation problems	☐ Constipation
☐ Vision	☐ Throat pain	☐ Coughing up blood		☐ Swallowing Difficulties
	☐ Choking			☐ Heart Burn
	☐ Hoarseness			☐ Diarrhea

GU	HEMATOLOGIC	SKIN	Musculoskeletal	Neuro
☐ Incontinence	☐ Abnormal bleeding or bruising	☐ Rashes	☐ arthritis	☐ Seizures
☐ Blood in urine				☐ Slurred speech
☐ Bladder infection				☐ Numbness
☐ Kidney stones				☐ Paralysis
				☐ Psychiatric Illness

RED RIVER ENT ASSOCIATES/RED RIVER SLEEP CENTER

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND IDENTITY THEFT PROTECTION

_______________________________________ _______________________________

PRINT Patients Name ***Patients Date of Birth***

I have been presented with a copy of the ***Red River ENT Associates/Red River Sleep Center's*** Notice of Privacy Policies, which details how my information may be used and declared and permitted under federal and state law. I understand the contents of the Notice and that my health information may be used for treatment, payment and health operations.

I understand that photographs, or other images may be recorded to document my care and my identity, and I consent to this. I understand that ***Red River ENT Associates/Red River Sleep Center*** will retain the ownership rights to these photographs or other images, but that I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in ***Red River ENT Associates/Red River Sleep Center's*** policy. Images that identify me will be released and/or used outside the institution only upon written authorization from my legal representative or me.

With regards to communications with my family and friends, ***Red River ENT Associates/Red River Sleep Center***, will not discuss or release any of my health information to any of my family members or friends unless that family member is my legal representative or is named below.

Family Member/Friend Name and Relationship to patient:

_______________________________________ ___________________________________

Name ***Relationship***

_______________________________________ ___________________________________

Name ***Relationship***

_______________________________________ ___________________________________

Name ***Relationship***

_______________________________________ ___________________________________

Name ***Relationship***

If the patient is a minor child, ***Red River ENT Associates/Red River Sleep Center*** will disclose his/her health information only to the mother and/or father of the child.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party accepting assignment. Regulations pertaining to medical assignment of benefits apply.

____

Signature of Patient or Legal Representative

____

Relationship to Patient

____

Date

( ) **Patient refused to sign acknowledgment:**

____ _______________________________________

Signature of Red River ENT Associates/Red River Sleep Center Representative ***Date***

8/29/13