RED RIVER E.N.T. & ASSOC.

Patient Information Form

☐ Dr. Paul Guillory ☐ Dr. Daniel Noel
☐ Dr. Renick Webb ☐ Dr. J. A. Badeaux III
☐ Dr. Christian Wold

Date _____

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

Name _____ Age _____ Date of Birth _____ Sex: ☐ male ☐ female
Last First Middle

If Patient is a Minor: Mothers Name: _____ Primary Phone # _____ Work # _____

Fathers Name: _____ Primary Phone # _____ Work # _____

Social Security # _____ Email _____

Mailing Address _____ APT# _____ City / State / Zip_____

Marital Status:_____ Spouse Name: _____ Spouse Contact #: _____

Phone: Home # _____ Cell # _____ Employer _____ Work # _____

Language:_____ Race _____ 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 _____

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

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: work # _____ other # _____

PATIENT INSURANCE INFORMATION

Insured Person _____ Employer _____ Social Security# _____
(Name on Insurance Card)

Insured Party DOB:_____ Relationship to Patient_____

I hereby instruct and direct my current Insurance Company to pay **: Red River ENT Associates**

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: **Red River ENT Associates**

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

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'*** 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*** 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'*** 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***, 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*** 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 Representative ***Date***

8/2019 kh