Camille A. Graham, M.D. Neil M. Vora, M.D. Wha-Joon Lee, M.D. Michael J. Wiebel, M.D.

Patient Information

Name (Last)_____(First)_____DOB____/____/____(Age)____
Social Security #_____ TDL# _____
Marital Status: S M D W Sex: M F Race: _____ Ethnicity:_____
Primary Language_____Preferred Communication_____
Address(Street)_____ (City)_____(St)_____(Zip)_____
Phone(Home)_____ (Cell)_____
Employer:_____Wk Phone:_____Email:_____

Parent/Guardian Information (if patient is under 18)

Name (Last)_____(First)_____DOB_____/_____/_____
Relationship to Patient:_____ Email:_____
Social Security #_____ TDL# _____
Marital Status: S M D W Sex: M F
Address(Street)_____ (City)_____(St)_____(Zip)_____
Phone(Home)_____ (Cell)_____
Employer:_____ Wk Phone:_____

Spouse Information

Name (Last)_____(First)_____DOB_____/_____/_____
Social Security #_____ TDL# _____
Marital Status: S M D W Sex: M F
Address(Street)_____ (City)_____(St)_____(Zip)_____
Phone(Home)_____ (Cell)_____
Employer:_____ Wk Phone:_____

Insurance Information

Primary Insurance:_____Insurance Phone#_____
Insured Name: _____DOB: _____Relationship to Patient_____
Insured ID#_____Group#_____Employer_____

Secondary Insurance: _____ Insurance Phone#_____
Insured Name: _____DOB: _____Relationship to Patient_____
Insured ID#_____Group#_____Employer_____

Emergency Contact **(NOT LIVING WITH YOU)**

Name (Last)_____(First)_____ Relation to Patient _____DOB _____
Phone(Home)_____(Work)_____(Cell)_____
Were you referred to us by another physician? ___ If yes Dr. (name) _____
Name of your Primary Care Doctor: _____
Preferred Pharmacy Name & Number: _____
What number can we contact you at? _____Can we leave a message?___
Family Members we can release information to: _____
_____
(Name) (Relationship)

Authorization to Treat, Authorization to Release Information & Assignment of Benefits, No Show & Results

I authorize the physician(s) of Allergy ENT to treat me. I authorize any physician/agent of Allergy ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of Allergy ENT. I authorize any physician/agent of Allergy ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay my medical benefits directly to the physician(s) of Allergy ENT. I understand that I am financially responsible for all charges not paid by the insurance carrier(s). I understand that if I fail to give correct insurance information and the office miss filing deadlines I am responsible for the charges in full. I understand if I have an HMO POLICY I am responsible for obtaining the referral and make sure I have a current referral for each visit . There will be a 25.00 no show fee if I no show my appointment. PLEASE NOTE RESULTS WILL NOT BE GIVEN OVER THE PHONE, A FOLLOW UP APPOINTMENT WILL BE REQUIRED

_____ Date:_____
Patient Signature (Parent or Guardian, if patient is a minor) New Patient Demographics 10/04/17 tjd

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here Date of Birth

_____

Signature Date

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read, understand and agree to the Financial Policy of Allergy, Ear, Nose & Throat Clinic.

_____

Signature of Patient or Legal Guardian Relationship to Patient Date

E-PRESCRIBING CONSENT (PBM)

By signing this consent form you are agreeing that Allergy ENT Clinic can request and use your prescription medication history from other healthcare providers/ pharmacy for treatment.

_____

Signature of Patient or Legal Guardian Relationship to Patient Date

CONSENT FOR TREATMENT OF MINOR CHILDREN
ACCOMPANIED BY AN ADULT OTHER THAN PARENT OR LEGAL GUARDIAN

I,_____, Authorize, Allergy ENT Clinic of NE TX to treat
(Parent or legal guardian)
_____for routine and emergency medical treatment
(Child's name and DOB)
when necessary by qualified medical personnel when accompanied by:

_____

This authorization is valid for:

- Today's visit only
- From _____(date) to_____(date)
- Until revoked in writing by me

This consent will be valid for (1) year from the date signed unless otherwise specified in writing.

_____

Printed name of parent/legal guardian

_____

Signature of parent/legal guardian Date

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