Austin Ear, Nose & Throat Clinic

My appointment is with:

PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION

PATIENT NAME	**Date of Birth**	**SSN#**	**MARITAL STATUS (circle one)** ☐ Single ☐ Married ☐ Divorced
ADDRESS	CITY	ST	ZIP
HOME PHONE EXT		MOBILE PHONE	EXT

ETHNICITY (circle one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to answer

GENDER (circle one) ☐ Male ☐ Female

RACE (circle one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Decline to answer ☐ Unknown

PRIMARY LANGUAGE (circle one) ☐ English ☐ Spanish ☐ Italian ☐ Chinese ☐ French ☐ Dutch ☐ Russian

Email Address		
Patients Employer	Address	Phone
Emergency Contact	Relationship to patient	Phone
Name of Referring Doctor	Address	Phone
Name of Primary Care Doctor	Address	Phone
List other Doctor's you're seeing for today's problem (first and last names please)		
Pharmacy Name	Address	Phone

INSURANCE INFORMATION

Primary Insurance	Effective Date	Name of Policy Holder, Relationship & Date of Birth	Ins Phone#
ID#	Group#	SSN#	
Secondary Insurance	Effective Date	Name of Policy Holder, Relationship & Date of Birth	Ins Phone#
ID#	Group#	SSN#	

Consent

I GIVE MY CONSENT FOR AENTC TO DISCUSS PATIENT'S MEDICAL CARE AND PAYMENT FOR MEDICAL CARE WITH THE FOLLOWING PEOPLE:

_____ name / relationship / phone number

_____ name / relationship / phone number

_____ name / relationship / phone number

_____ name / relationship / phone number

PATIENTS READ AND SIGN AGREEMENT

1-- I hereby give my consent for physicians of Austin ENT Clinic to evaluate and treat the above patient.
2-- I have been provided with the Privacy Practices Notice for Austin Ear, Nose & Throat Clinic.
3-- I understand that my personal health information will be used for the purpose of treatment, payment, and the coordination of health care needs of the patient.
4-- I have also been provided and agree with the Financial Policy of AENTC.
5-- I understand that I am personally responsible for all provider charges if I choose to seek "out-of-network" services from this provider.

Signature of patient or guardian:_____ **DATE:**_____

PATIENT INFORMATION PAGE FOR A CHILD OR DEPENDENT ADULT

Patient Name:_____ **DOB:**_____

First Responsible Party (Parent or Guardian of a minor under 18 or dependent child)					
1st Guardian's Name				Soc. Sec #	
Date of Birth	Relationship			Home Ph#	Mobile#
Address				License#	
City	State	Zip	Email		
1st Guardian's Employer		Occupation			Business Ph#
Second Responsible Party (Parent or Guardian of a minor under 18 or dependent child)					
2nd Guardian's Name				Soc. Sec #	
Date of Birth	Relationship			Home Ph#	Mobile#
Address				License#	
City	State	Zip	Email		
2nd Guardian's Employer		Occupation			Business Ph#

Divorced Parents

In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court document that specifieshe child's healthcare needs.

According to decree, which parent may consent to
treatment and coordination healthcare needs (not surgical) _____

According to decree, which parent may give
consent for surgical procedures (invasive procedures) _____

CONSENT FOR MINORS OR DEPENDENT ADULTS

IMPORTANT NOTE: On all initial consultations, the legal parent or guardian MUST BE PRESENT

Please state who may bring the child in for follow-up other than the legal parent or guardian

Name	Relationship	Phone#
Address		
Name	Relationship	Phone#
Address		
Name	Relationship	Phone#
Address		

THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR