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 / Unknown	Non-Hispanic or Latino / Decline to answer	GENDER (circle one) Male Female
RACE (circle one) White	American Indian/Alaska Native / Native Hawaiian/Pacific Islander	Asian / Decline to answer	Black/African American / 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 if I am personally responsible for all provider charges if 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