Patient Information Form

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

Patient Name ____ Age __________ Date of Birth ________________________ Race _____________
Last First Middle

Sex: □ male □ female Social Security Number _______-_______-_______ Drivers License # / State _____________________________________

Mailing Address ____ APT # _______ City / State / Zip _____________________________

Email: ____ Marital Status: ____________________________

Telephone: Home # __________________ Cell # ___________________ Work # ____________________ Employer ___________________________

Language: _______________________________ Ethnicity (please select one): □ Hispanic □ Non-Hispanic □ Refused to Respond

Primary Care Physician ____ Referring Physician/Facility ____

Emergency Contact ______________________________________ Phone # ________________________ Relationship __________________________

Preferred Pharmacy & Location ____ **Drug Allergies** ___________________________________

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

Name ________________________________ Social Security # ___________________ DOB ____________ Employer ____________________________

Address ____ Phone: home # ___________________ other # ______________________

PATIENT INSURANCE INFORMATION

Primary Insurance ___________________________ Policy # ___________________________________ Group # ________________________________

Insured Name _________________________ Policy Holder's DOB _____________SSN ______-______-______ Relationship to Patient _________________
Name on Insurance Card

Secondary Insurance ________________________ Policy # ___________________________________ Group # ________________________________

Insured Name _________________________ Policy Holder's DOB _____________SSN ______-______-______ Relationship to Patient _________________
Name on Insurance Card

I hereby authorize East Texas Ear, Nose, & Throat (Ryan M Guillory MD PA) to furnish my health insurance company or other third party payers or their designated agents all the information which the above named entities may request concerning treatment of the patient names above.

I hereby assign to East Texas Ear, Nose, & Throat (Ryan M Guillory MD PA) the medical and\or surgical benefits to which I or my dependents are entitled under my health insurance plan.

I hereby authorize East Texas Ear, Nose, & Throat (Ryan M Guillory MD PA) to download my current medication information into my medical chart.

I understand patients canceling or rescheduling any surgery or office visit at patient's request within one business day for office visits and two business days for surgeries may be charged a cancellation and/or rescheduling fee.

I understand that regardless of insurance coverage, 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.

____ ____________________

Signature of patient or legal guardian Date

EAST TEXAS EAR, NOSE, & THROAT

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 ***East Texas Ear, Nose, & Throat*** 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 ***East Texas Ear, Nose, & Throat*** 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. 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, ***East Texas Ear, Nose, & Throat***, 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, ***East Texas Ear, Nose, & Throat*** 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 East Texas Ear, Nose, & Throat Representative	***Date***

2-20-18