Austin Ear, Nose & Throat Clinic **My appointment is with:**

PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION

PATIENT NAME	Date of Birth	SSN#	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced
ADDRESS	CITY	ST	ZIP
HOME PHONE		MOBILE PHONE	

ETHNIC ORIGIN
☐ White ☐ Hispanic or Latino ☐ Black or African American ☐ Native American or American Indian ☐ Asian/Pacific Islander ☐ Other

GENDER ☐ Male ☐ Female	EMAIL ADDRESS

PRIMARY LANGUAGE
☐ English ☐ Spanish ☐ Italian ☐ Chinese ☐ French ☐ Dutch ☐ Russian

PATIENT'S EMPLOYER	Address	Phone
EMERGENCY CONTACT	Relationship to patient	Phone
NAME OF REFERRING DOCTOR	Address	Phone
NAME OF PRIMARY CARE DOCTOR	Address	Phone
List other doctors you're seeing for today's problem		
PHARMACY NAME	Address	Phone

INSURANCE INFORMATION

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

Consent

I GIVE MY CONSENT FOR AUSTIN EAR, NOSE & THROAT CLINIC 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 – PLEASE READ AND SIGN AGREEMENT

1. I hereby give my consent for physicians of Austin Ear, Nose & Throat Clinic to evaluate and treat the above-named patient.

2. I have been provided the Notice of Privacy Practices 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 Austin Ear, Nose & Throat Clinic.

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	Date of Birth		Relationship	SSN	Driver's License #
Address	City	State	ZIP	Email	
Home Phone #	Mobile Phone #				
1st Guardian's Employer	Occupation			Business Phone #	

Second Responsible Party (Parent or Guardian of a minor under 18 or dependent child)

2nd Guardian's Name	Date of Birth		Relationship	SSN	Driver's License #
Address	City	State	ZIP	Email	
Home Phone #	Mobile Phone #				
2nd Guardian's Employer	Occupation			Business Phone #	

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 specifies the child's healthcare needs.

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

According to the 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	Address	Relationship	Phone #
Name	Address	Relationship	Phone #
Name	Address	Relationship	Phone #
Name	Address	Relationship	Phone #

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