McKinney ENT
Socorro Chamblee, M.D.

THIS FORM NEEDS TO BE COMPLETED IN FULL

PATIENT INFORMATION **DATE: ______/______/________**

If your insurance program requires a referral, it is your responsibility to obtain this before your appointment time; otherwise we are required to reschedule this appointment. When registering, please present proof of insurance, Medicare and/or Medicaid and your Driver's License.

Patient Information

Full Legal Name: ________________________________ Date of Birth: ____________ Age: ____ Sex : ____

Address: ________________________________ City: _________________ State: ______ Zip Code: _______
(Mailing address)

Phone (home) __________________ Work/Cell ______________________ Single Married Divorced Widowed

Driver's License # ________________ Social Security # ___________-________-___________

Employer __________________________________ Occupation _____________________________________

Insurance Information of Insured

Name of Insured _____________________________ Date of Birth ___________ Relationship to Patient ________

Address ____________________________ City _____________ State _____ Zip _______ Phone _____________

Social Security # ______/______/______

Employer ___________________________ Work Phone _____________ Occupation ______________________

Name of Insurance Company ____ Phone ______________________

Address (for claims) ____

City _______________________________ State ________ Zip ___________

Member ID # _______________________________________ Group # _________________________________

Spouse/Guardian

Name ______________________________ Date of Birth _________________ Relationship to Patient ________

Address ____________________________ City ____________ State _______ Zip _____ Phone _____________

Employer ____ Work Phone _______________________________

Social Security # _______/________/___________

Please provide a telephone number we may leave a private message to remind you about appointments & results.

Private Telephone Number ____

Primary Physician ______________________________________ Phone ______________________________

Referring Physician _____________________________________ Phone ______________________________

Address ______________________________________ City _______________ State _____ Zip ___________

NAME OF SOMEONE TO CONTACT IN CASE OF AN EMERGENCY ______________________________

RELATIONSHIP ________________ HOME PHONE ____________________ WORK/CELL______________

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I AUTHORIZE SOCORRO CHAMBLEE, M.D. TO RELEASE AND FURNISH ON A CONFIDENTIAL AND STRICT NEED TO KNOW BASIS ALL MEDICAL AND FINANCIAL DATA RELATED TO MY CARE THAT MAY BE NECESSARY NOW OR IN THE FUTURE TO FACILITATE PAYMENT BY THIRD PARTIES FOR SERVICES RENDERED BY PHYSICIAN, OR TO ASSIST WITH, AID IN, OR FACILITATE THE COLLECTION OF DATA FOR PURPORSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, OR MEDICAL OUTCOMES EVALUATION PURPOSES. SUCH INFORMATION MAY BE RELEASED TO INSURANCE COMPANIES, HMO'S, PPO'S, MANAGED CARE ORGANIZATIONS, INDEMNITY PLANS, MEDICARE/MEDICAID OR OTHER GOVERNMENTAL OR THIRD PARTY PAYERS, OR ANY ORGANIZATIONS CONTRACTING WITH ANY OF THE ABOVE ENTITIES TO PERFORM SUCH FUNCTIONS. I ALSO GIVE MY AUTHORIZATION TO HAVE A COPY OF MY MEDICAL RECORDS DELIVERED TO MY PRIMARY CARE PHYSICIAN FOR MY MEDICAL CARE OR THE PAYMENT THEREOF.

PATIENT'S SIGNATURE ____

PATIENT'S RESPONSIBILITY

SIGNING OF THIS FORM IN NO WAY IMPLIES THAT YOUR VISITS WITH THIS OFFICE WILL BE COVERED BY YOUR INSURANCE COMPANY, SOCORRO CHAMBLEE, M.D.; AND THEIR EMPLOYEES CANNOT GUARANTEE ANY INFORMATION GIVEN TO US BY YOUR INSURANCE CARRIER REGARDING YOUR BENEFITS.

1. IF YOU ARE NOT PART OF AN HMO, PPO, MEDICARE/MEDICAID, OR MANAGED CARE CHOICE PLAN THAT WE PARTICIPATE IN, YOU WILL BE RESPONSIBLE FOR YOUR BILL AT THE TIME OF SERVICE.
2. IF YOU ARE PART OF A PPO PLAN AND YOU HAVE A DEDUCTIBLE FOR SERVICES OTHER THAN YOUR REGULAR OFFICE COPAY, YOU WILL BE RESPONSIBLE FOR PAYMENT OF SAID DEDUCTIBLE.
3. IF YOU ARE PART OF A MANAGED CHOICE OR HMO PLAN, FAILURE TO OBTAIN A VALID REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (PCP), MAY RESULT IN NO BENEFTIS BEING PAID. YOU WILL BE RESPONSIBLE FOR ANY NON-PAYMENT FROM YOUR INSURANCE CARRIER.
4. DUE TO CONTRACT LANGUAGE BETWEEN PHYSICIAN AND INSURANCE COMPANY, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES DEEMED TO BE "NON-APPROVED" BY MY INSURANCE COMPANY BUT THAT I STILL MAY OWE THE PROVIDER FOR SERVICES RENDERED.

PATIENT'S SIGNATURE ____

DATE ____

McKinney Ear, Nose & Throat Clinic

8080 Independence Pkwy, Suite 255 Plano, TX 75025
Phone: 214-383-5955 Fax: 214-383-5966

Patient Name: ____________________ **Age/Date of Birth:** ____________________

Referring Physician: ____________________ Primary Physician: ____________________

Address & Phone Number of Primary Care Physician: ____________________

Reason for your visit: ____________________ Date: ____________

What medications are you currently taking? Include over-the-counter medications. ____________

____

Allergies to medications? Y N If yes, which ones and what reaction do you have with them?

____

Past Surgical History (list type of surgery and date): ____________________

____

Past Medical History (list major medical illnesses and date of onset): ____________________

____

Please check all that **DO** and **DO NOT** apply:

Eyes	YES	NO
Blurry Vision :	☐	☐
Double Vision:	☐	☐
Ear/Nose/Mouth/Throat	**YES**	**NO**
Ears:		
Ear Drainage	☐	☐
Hearing Problems	☐	☐
Balance Problems	☐	☐
Ringing in Ears	☐	☐
Nose:	YES	NO
Runny Nose:	☐	☐
Excessive Sneezing:	☐	☐
Nasal Itching:	☐	☐
Watery Eyes:	☐	☐
Smell Lost:	☐	☐
Snoring:	☐	☐
Nasal obstruction	☐	☐

Throat:	YES	NO
Difficulty swallowing:	☐	☐
Painful Swallowing:	☐	☐
Change in taste:	☐	☐
Sore Throat:	☐	☐
Heart Burn:	☐	☐
Hoarseness:	☐	☐
Gastrointestinal	**YES**	**NO**
Vomiting:	☐	☐
Nausea:	☐	☐
Blood in Stools or Vomit:	☐	☐
Abdominal Pain	☐	☐
Diarrhea:	☐	☐
Jaundice:	☐	☐
Respiratory	**YES**	**NO**
Wheezing	☐	☐

Respiratory continued...	YES	NO
Cough	☐	☐
Shortness of Breath	☐	☐
TB	☐	☐
Stridor	☐	☐
Coughing Blood	☐	☐
Neurologic	**YES**	**NO**
Seizures	☐	☐
Paralysis	☐	☐
Numbness/Tingling	☐	☐
Headache	☐	☐
Migraine	☐	☐
Musculoskeletal	**YES**	**NO**
Bone/Joint pain	☐	☐
Psychiatric	**YES**	**NO**
Feeling Depressed	☐	☐

Psychiatric continued...	YES	NO
Panic Attacks	☐	☐
Hematologic/Lymphatic	**YES**	**NO**
Anemia	☐	☐
Blood Transfusions	☐	☐
Clotting problems	☐	☐
High Cholesterol	☐	☐
Cardiovascular	**YES**	**NO**
Palpitations:	☐	☐
Chest Pain	☐	☐
Elevated Blood Pressure	☐	☐
Foot swelling	☐	☐
Endocrine	**YES**	**NO**
Thyroid Problems	☐	☐
Excessive Thirst:	☐	☐
Genitourinary	**YES**	**NO**
Blood in urine	☐	☐

If female, are you currently pregnant? Y N Are you breastfeeding? Y N

Social History: Do you consume caffeine? Y N If yes, how much and how often? ____________

Do you drink alcohol? Y N If yes, how much and how often? ____________________

Do you **currently** use tobacco products? Y N If yes, what type, how much and how often? ____________

Have you **ever** used tobacco products in the **past**? Y N If yes, what type and how much? ____________

When did you stop using tobacco products? ____________________

Do you have a history of drug abuse of any kind? Y N ____________________

Family History: (Circle Y or N, if Yes please list which family member)

Allergies: Y N____________ Asthma: Y N____________ Diabetes: Y N____________

Bleeding Disorders: Y N ____________ Heart Disease: Y N ____________ Cancer: Y N ____________

High Blood Pressure: Y N____________ Hearing Loss: Y N____________

Problems with anesthesia: Y N____________ Other: ____________

(Office use only) Reviewed/Updated by: Date_______/ Initials ________, Date_______/ Initials ________,

Date_______/ Initials ________, Date_______/ Initials ________, Date _______/ Initials ________