

## REGISTRATION

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex M F Age \_\_\_\_\_ Birth date \_\_\_\_\_ Single Married Widowed Separated Divorced  
 Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Insured Name \_\_\_\_\_ How and where did you learn about this clinic? \_\_\_\_\_  
 Last Name First Name Initial  
 Relationship To Insured Self Spouse Child Other  
 Condition/ Illness Related To Illness Employment Auto Other

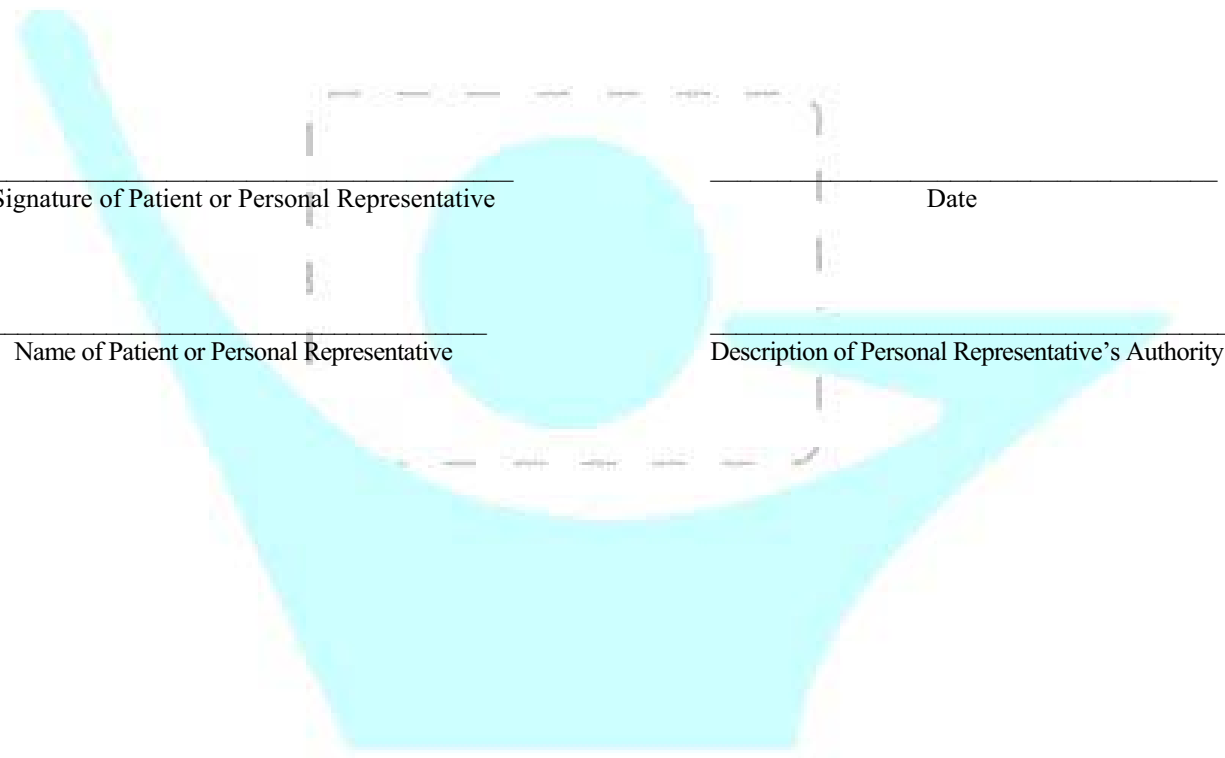
<b>EMPLOYER</b>	Company Name _____ Occupation _____ Address _____ Phone _____ Full-time _____ Part-time _____ City _____ State _____ Zip _____ Years Employed _____
<b>SPOUSE (PARENT)</b>	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ Full-time _____ Part-time _____
<b>PATIENT INSURANCE INFORMATION</b>	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
<b>SPOUSE COINSURANCE INFORMATION</b>	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
<b>MEDICAL AND LEGAL INFORMATION</b>	<b>Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? Yes No</b> Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
<b>Patient Agreement &amp; Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing &amp; Reimbursement As Required by Federal and State Laws</b>	<b>Legal Assignment Of Benefits And Designation Of Authorized Representative</b> In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u> , all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.</u> I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.
	_____ Signature of Insured / Guardian
	_____ Date

# WEST HOUSTON ENT & SLEEP CENTER

12606 West Houston Center Blvd #220 Houston, Texas 77082  
Phone: 281-556-1102 - Fax: 281-556-1340

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.



_____ Signature of Patient or Personal Representative	_____ Date
_____ Name of Patient or Personal Representative	_____ Description of Personal Representative's Authority

**Payment Policy**

**\*\*\* Please note: ALL PAYMENT IS DUE AT THE TIME OF SERVICE \*\*\***

In order for Dr. James Ludwick to adequately evaluate and diagnose your complaint/illness you may require an in-office procedure. Common diagnostic procedures include:

- Nasal Endoscopy/Nasopharyngoscopy
- Flexible Laryngoscopy
- Removal of impacted cerumen to allow visualization of the ear drum
- Use of microscope

In addition, common in-office therapeutic procedures include:

- Inferior turbinate reduction
- removal of nasal or ear foreign bodies
- cerumen removal
- Pillar Procedure
- biopsies
- nasal debridement

You may be responsible for the charges associated with these procedures which typically range from \$50 - \$250 (\$90 - \$1500 for therapeutic procedures). This will depend on your specific health care benefits from your insurance provider. As a courtesy, at the time of your visit we will do our best to notify you of any co-insurance or deductibles which apply to your policy, *but it is ultimately your responsibility to know what your health care policy covers.*

These payments are expected at the time of service unless prior written arrangements have been made with our office. If, upon receiving your explanation of benefits (EOB) from your insurance carrier, an overpayment was made on your part, a refund will be mailed to the address on file with our office.

Please feel free to ask the receptionist if you have any questions regarding this policy so we can minimize any confusion concerning our charges.

Thank you,

West Houston ENT & Sleep Center  
Billing and Insurance Dept.

**I acknowledge that I may be responsible for payment due at the time of service other than my office visit co-pay or deductible due to my benefit plan.**

X \_\_\_\_\_

Patient/Guardian Signature

X \_\_\_\_\_

Date

X \_\_\_\_\_

Patient name

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## New Patient Health History

**IN YOUR OWN WORDS, WHAT BRINGS YOU TO SEE US TODAY?** \_\_\_\_\_

**PLEASE TELL US YOUR:      HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **lbs**

**PAST HEALTH HISTORY:** Has your doctor ever told you that you have any of the following (These are **NOT** symptoms)?

**Face:**

Skin Cancer No Yes When? \_\_\_\_\_  
 Type Basal Cell Squamous Cell Melanoma  
 Bell's Palsy/Facial weakness No Yes When? \_\_\_\_\_

**Ears:**

Recurrent Infections No Yes When? \_\_\_\_\_  
 Hearing Loss No Yes When? \_\_\_\_\_  
 Ear Fluid No Yes When? \_\_\_\_\_  
 Cholesteatoma No Yes When? \_\_\_\_\_

**Nose & Sinus:**

Nasal Allergies No Yes When? \_\_\_\_\_  
 Sinusitis No Yes When? \_\_\_\_\_  
 Nasal Polyps No Yes When? \_\_\_\_\_  
 Nose Bleeds No Yes When? \_\_\_\_\_

**Cardiovascular:**

Arrhythmia No Yes When? \_\_\_\_\_  
 Heart Valve Disease No Yes When? \_\_\_\_\_  
 High Blood Pressure No Yes When? \_\_\_\_\_  
 High Cholesterol No Yes When? \_\_\_\_\_  
 Heart Attack No Yes When? \_\_\_\_\_

**Pulmonary:**

Asthma No Yes When? \_\_\_\_\_  
 Emphysema/COPD No Yes When? \_\_\_\_\_  
 Sleep Apnea No Yes When? \_\_\_\_\_  
 Tuberculosis No Yes When? \_\_\_\_\_  
 Use oxygen at home No Yes When? \_\_\_\_\_

**Have you ever had:**

Hepatitis No Yes When? \_\_\_\_\_  
 HIV No Yes When? \_\_\_\_\_  
 Mononucleosis No Yes When? \_\_\_\_\_

**Stomach/Digestive:**

Reflux No Yes When? \_\_\_\_\_  
 Liver Disease No Yes When? \_\_\_\_\_  
 Gastric/duodenal Ulcers No Yes When? \_\_\_\_\_

**Kidney:**

Kidney Stones No Yes When? \_\_\_\_\_  
 Renal Failure No Yes When? \_\_\_\_\_

**Endocrine**

High blood calcium No Yes When? \_\_\_\_\_  
 Diabetes No Yes When? \_\_\_\_\_  
 Thyroid Disease No Yes When? \_\_\_\_\_  
     Hyperthyroidism Hypothyroidism  
     Nodule

**Blood/Lymph Nodes:**

Anemia No Yes When? \_\_\_\_\_  
 Bleeding Disorder No Yes When? \_\_\_\_\_  
 Leukemia/Lymphoma No Yes When? \_\_\_\_\_

**Have you ever been diagnosed with cancer?**

No Yes **Please list location and year diagnosed.**  
 Location \_\_\_\_\_ Year \_\_\_\_\_  
 Location \_\_\_\_\_ Year \_\_\_\_\_

**Neurological/Psychiatric** (please check which applies to you)

Stroke Parkinson's Alzheimer's Seizures  
Depression Anxiety Disorder Panic Attacks

**Have we missed anything?** \_\_\_\_\_

**SURGERIES:** (Please include type or location and year of surgery)

EAR TUBES TONSILLECTOMY SINUS SURGERY  
SEPTUM SLEEP SURGERY RHINOPLASTY  
 OTHER: \_\_\_\_\_

**Have you ever been hospitalized?** No Yes

**Have you ever had a problem with anesthesia?** No Yes  
 Reaction \_\_\_\_\_

**CURRENT MEDICATIONS:**(Includes all prescription, over-the-counter medications, herbal and vitamin supplements)

CHECK **HERE** IF YOU DON'T TAKE ANY MEDICATIONS

Name of Medication	Dose	Times/day

**Do you take:** Aspirin    Plavix    Coumadin    Ginko Biloba    Ginseng    Echinacea    Garlic

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## New Patient Health History

**MEDICATION ALLERGIES:**  CHECK HERE IF YOU HAVE NO MEDICATION ALLERGIES

Name of Medication	Type of Reaction (ex: rash, hives, swelling)

**SOCIAL HISTORY:**

**I think my overall health is:**  Excellent  Good  Average  Fair  Poor  
**Marital Status**  Married  Separated  Divorced  Widowed  Single  Significant Other  
**Children?**  No  Yes Number \_\_\_\_\_  
**Occupation:** \_\_\_\_\_  Full Time  Part time  
**Are you a Jehovah Witness?**  No  Yes  
**Exercise regularly?**  No  Yes **Days/Week:** \_\_\_\_\_  
**Have you ever used illicit drugs?**  No  Yes  
 Do you *currently* use them?  No  Yes  
**Type:** \_\_\_\_\_  
**Do you use or have you used tobacco products?**  No  Yes  
 || **If yes, year began?** \_\_\_\_\_  
 ||  Cigarettes Packs/day \_\_\_\_\_  Chew Tobacco  
 ||  Cigar/Pipe Number/day \_\_\_\_\_  
 || **Quit?**  No  Yes **Year** \_\_\_\_\_  
 || **Do you drink alcoholic beverages?**  No  Yes  
 || **If yes**  Occasionally  Daily (**Drinks/day**) \_\_\_\_\_  
**How many cups of caffeinated beverages do you drink/day?** ||  1-3  3-5  5-7  >7

**FAMILY HISTORY:**

<b>Problems with anesthesia</b>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Ears:</b>				
Hearing loss before age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing loss after age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Nose &amp; Sinus:</b>				
Nasal Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nose Bleeds	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nasal Polyps	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Cardiovascular</b>				
Heart Attack	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Cholesterol/Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Pulmonary:</b>				
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lung Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Gastrointestinal</b>				
Stomach/Esophageal Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Reflux	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Nervous System</b>				
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Brain Tumors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Blood &amp; Lymph Nodes</b>				
Bleeding/Clotting Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Leukemia/Lymphoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<b>Other:</b> _____				

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## New Patient Health History

### REVIEW OF SYSTEMS:

#### General Health Problems

- Fatigue  Fever/Chills  Headache  Loss of appetite  
 Night Sweats  Recent Illness  Weight loss

#### Eye

- Blurry Vision  Bulging of eyes  Double Vision  
 Itchy/Watery Eyes

#### Ear

- Ear Pain  Hearing Loss  Drainage  
 Infections #/yr \_\_\_\_\_  Dizziness/Vertigo  
 Ringing  Fullness  Popping Sensations

#### Nose & Sinus

- Nasal Congestion  Nasal Drainage  Post-Nasal Drip  
 Facial Pain  Nose Bleeds  Nasal Obstruction

#### Mouth & Throat

- Hoarseness  Change in Voice  Snoring  
 Ulcers  Sore Throat  Witnessed Apnea  
 Recurrent Throat Infections #/yr \_\_\_\_\_  
 Difficulty Swallowing  Painful Swallowing  
 Sense a "lump" in throat

#### Neck

- Neck Mass  Pain  Lymphadenopathy

#### Endocrine/Glands

- Change in thirst/appetite  Feel cold all the time  
 Neck has enlarged  Feel hot all the time  
 Change in Appetite  Weight Loss

#### Allergy

- Food intolerances  Itchy/watery eyes  
 Mold Allergy  Seasonal allergies  
 Receive Allergy Shots  Sneezing  
 Allergy symptoms all year long

#### Do you have any of the following symptoms:

- Spouse/significant other says you stop breathing when sleeping  Snore Loudly  Dry mouth in the morning  
 Sleepy during the day  Uncontrollable sleep attacks  Restless sleep  
 Creepy/crawling sensations in legs when trying to sleep  Leg kicking while sleeping  
 Wake up feeling paralyzed  Hallucinate when waking up/falling asleep  
 Difficulty falling asleep  Difficulty staying asleep  Waking up too early  
 Worrying at bedtime  Take sleeping pills  Drink alcohol to help you fall asleep

#### Pulmonary

- Non-productive cough  Wheezing  
 Productive cough  Shortness of Breath  
 Stridor  Pneumonia  Cough up blood

#### Cardiovascular

- Swelling of Ankles/legs  Chest Pain  
 Blacking out/fainting  Irregular Heartbeat

#### Stomach/GI System

- Cough while eating  Heartburn/Reflux  
 Nausea  Stomach Problems  
 Vomiting

#### Genito/Urinary

- Are You Pregnant?  Urinate Frequently at Night

#### MusculoSkeletal

- Back Pain  Muscle Pain  Muscle Cramps  
 Bone Pain

#### Nervous System

- Balance Problems  Numbness  Seizure  
 Pass Out  Weakness

#### Integument/Skin

- Change in Skin Lesion  Form large scars  
 Non-healing Wound  Rash

#### Blood/Lymph Nodes

- Bleed Excessively  Bruise Easily  
 Swollen Glands  Frequent Nose Bleeds

#### Psychiatric

- Depression  Anxiety  Excessive Stress