Patient Intake Form

Last Name:_____ First Name: _____ M.I.: _____

Date of Birth: _____ Age: _____ Sex: □ F □ M Social Security Number: _____

Address:_____ Apt. #: ____ City: _____ State:____ Zip Code:_____

Home Phone:_____ Mobile Phone: _____ Preferred: □ Home □ Mobile

Consent to Call: □ Yes □ No / Consent to Text: □ Yes □ No Preferred Language: □ English □ Spanish □ ASL

Email:_____

Race: □ African-American/Black □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ European American/White Ethnicity: □ Hispanic/Latino Origin □ Not Hispanic/Latino

Marital Status: □ Single □ Married □ Widowed/Widower □ Divorced □ Other _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____ Relation:_____

Occupation: _____ □ Retired Work Phone:_____

How were you referred to us? □ Physician □ Insurance □ Facebook □ Instagram □ Twitter □ YouTube

□ Hospital/ ER - Name:_____ □ Existing Patient - Name:_____

□ RealSelf □ Website □ EASTside Magazine □ The Best Of Magazine □ Networking Event □ Radio

Parent/ Guardian/ Guarantor Information

Last Name:_____ First Name: _____ M.I.: _____

Date of Birth: _____Age: _____ Sex: □ F □ M Social Security Number: _____

Address:_____ Apt. #: _____ City: _____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone: _____ Preferred: □ Home □ Mobile

Relation to Patient: □ Parent □ Guardian □ Guarantor □ Spouse □ Employer □ Other: _____

Insurance Information

Primary Carrier: _____ Insured Name:_____

Sex: □ F □ M Member ID: _____ Group: _____ Relation: □ Self □ Other

Secondary Carrier: _____ Insured Name:_____

Sex: □ F □ M Member ID: _____ Group: _____ Relation: □ Self □ Other

Health History

Allergies: _____

Current Medications: _____

_____

Social History

Smoking/Tobacco: □ Non-Smoker □ Former Smoker - *Years Used* _____ □ Current Smoker - *Packs Per Day* _____

Alcohol Use: □ None □ Social □ Occasional □ Daily - *Drinks Per Day* _____

Medical History

□ Allergies	□ Anxiety	□ Asthma	□ Depression	□ Diabetes
□ High Cholesterol	□ Thyroid Disease	□ Sleep Apnea	□ Snoring	□ Hearing Loss
□ Sore Throat	□ Headache	□ Head Trauma	□ Sinus Issues	□ Ringing in the Ears
□ Vertigo/ Dizziness	□ Cancer	□ Chemotherapy	□ Dementia/Alzheimer's	
□ Hypertension/ High Blood Pressure		□ Hearing Aid Use		

Family History

Please Indicate: Mother, Father, Sister, Brother, Son, Daughter, Grandparent, Uncle, Aunt, Etc.

□ Allergies: _____ □ Anxiety: _____ □ Asthma: _____

□ Depression: _____ □ High Blood Pressure: _____ □ Hearing Loss: _____

□ Diabetes: _____ □ Cancer: _____ □ High Cholesterol: _____

□ Thyroid Disease: _____ □ Sleep Apnea: _____ □ Dementia/ Alzheimer's: _____

□ Other: _____

Surgical History: □ None

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Authorization and Release

By signing this consent form, I acknowledge that I have read, understand and voluntarily consent to and authorize the following:

Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray and medication for myself and for my dependents.

Guarantee of Payment:

_____ Initial ☐ Self Pay – I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by The Comprehensive ENT Center of Texas or The Comprehensive Hearing Center of Texas.

_____ Initial ☐ Insurance – Assignment of Benefits: I authorize payment directly to The Comprehensive ENT Center of Texas for all benefits otherwise payable to me. I also acknowledge that The Comprehensive ENT Center of Texas will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and The Comprehensive ENT Center of Texas's current contract with my insurance carrier. I understand this is only an estimate, and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While The Comprehensive ENT Center of Texas makes every effort to verify my correct insurance information prior to leaving, I understand The Comprehensive ENT Center of Texas cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier.

Release of Medical Records:

I authorize The Comprehensive ENT Center of Texas to release verbally. Electronically and/or in writing confidential medical information to any person or entity, including my insurance carrier, employer (if treatment is related to employment), immediate family member(s) and/or health care provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity and/or person(s), I must specifically state so in writing to be kept in my medical record.

Receipt of Financial Policy:

By signing this consent form, I acknowledge that a copy of the Financial Policy of The Comprehensive ENT Center of Texas is available to me upon request and can be downloaded at www.drleeman.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Receipt of Primary Practice:

By signing this consent form, I acknowledge that a copy of the Notice of Practice of The Comprehensive ENT Center of Texas is available to me upon request and can be downloaded at www.drleeman.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature Date

Comprehensive ENT Center of Texas
Comprehensive Hearing Center of Texas
3607 Manor Rd. Suite 101 Austin, TX 78723

PHOTO / VIDEO CONSENT FORM

You are very important to us! This form of photo/video consent is just as important and we ask that you read it with confidence and please take your time before making a decision. If you have any question or concerns please speak to our Medical Receptionist.

Do you give photo/video consent for the uses listed below? ☐ Yes (continue filling out this form) ☐ No

I, _____,(Print Full Name) the undersigned, do hereby grant permission to Dr. Daniel J. Leeman's office to use the photograph(s)/film/video(s) of myself taken by a physician or team member of Daniel J. Leeman, MD as marked by my signature below. Such use includes the display, distribution, publication, transmission or otherwise use of photograph(s)/film(s)/ video(s) taken of myself for use in materials that include, but may not be limited to: purposes of social media posts (Snapchat, YouTube, Twitter, LinkedIn, Facebook and Instagram), advertising, newsletters, written testimonials, promo videos and digital images such as those on the Dr. Daniel J. Leeman's office website.

_____ (Initials) Unrestricted usage: I give unrestricted permission for my image to be used in print, video and digital media. I agree that these images may be used by Dr. Daniel J. Leeman's office for a variety of purposes and that these images may be used without further notifying me. I do understand that the last name will not be used in conjunction with any video or digital images.

Patient/Guardian Signature _____ **Date** _____

Witness/Team Member Signature _____ **Date** _____

Dr. Daniel J. Leeman, MD

Comprehensive ENT Center of Texas

Comprehensive Hearing Center of Texas

Mueller Surgery Center

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www.drleeman.com

O: 512-478-CARE (2273)

C: 512-797-8467

F: 512-472-0921

3607 Manor Rd., Suite 101, Austin, TX, 78723

If you have any questions, contact Becca Herrera, Practice Administrator at 512-478-2273 ext 101.

The ComprEhensive ENT Center of Texas

Acknowledgment 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