ATX FACIAL PLASTICS

A Division of 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:** _____