

Sinus and ENT Center of Texas

Tracy Byerly II MD PA

New Patient Intake Form

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ Date of Birth: _____ Age: _____ Sex: F M Other

Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: Single Married Divorced Widowed Separated

Parent/Legal Guardian: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care (Family) Physician/ Pediatrician: _____

PCP Phone: _____ PCP Address: _____

Referring Physician Name & Phone Number (if different): _____

Referring Physician Address: _____

Preferred Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Medical Insurance

Policy Holder Name: _____ Policy Holder SSN _____ Policy Holder DOB: _____

Plan Name: _____ Patient's Policy #: _____

Group Name (if applicable) _____ Group Number (if applicable): _____

Insurance Co. Phone Number: _____ Specialist Copay: _____

Secondary Medical Insurance

Policy Holder Name: _____ Policy Holder SSN _____ Policy Holder DOB: _____

Plan Name: _____ Patient's Policy #: _____

Group Name (if applicable) _____ Group Number (if applicable): _____

Insurance Co. Phone Number: _____ Specialist Copay: _____

First Name: _____ Last Name: _____ DOB: _____

I hereby authorize all employees and agents of Sinus and ENT Center of Texas- Tracy Byerly II MD PA (including but not limited to physicians, physician assistants, nurse practitioners, nurses, and other employees) to render medical evaluations and care to the above-mentioned patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency. I hereby authorize payment directly to Sinus and ENT Center of Texas- Tracy Byerly II MD PA for any surgical and/or medical benefits, if any, otherwise payable to me. I authorize Sinus and ENT Center of Texas- Tracy Byerly II MD PA to release medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I understand that I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Sinus and ENT Center of Texas- Tracy Byerly II MD PA. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Responsible Party Printed Name: _____ Relation: _____

Signature: _____ Date: _____

Financial Responsibility/Notice of Privacy Practices Acknowledgement/Patient Portal/PRISMA/External Rx History

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Sinus and ENT Center of Texas- Tracy Byerly II MD for medical services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts such as copays are due upon request and are payable to Sinus and ENT Center of Texas- Tracy Byerly II MD

Initial _____ Date _____

I understand that I have immediate access at all times to the Sinus and ENT Center of Texas- Tracy Byerly II MD Notice of Privacy Practices via online website www.sinuscentertx.com Should you prefer a hard copy, one can be printed for you upon request. You will also notice a physical copy attached to this intake clipboard. The notice of privacy practices describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Sinus and ENT Center of Texas- Tracy Byerly II MD Notice of Privacy Practices.

Initial _____ Date _____

I understand that Sinus and ENT Center of Texas- Tracy Byerly II MD PA will automatically register me for a secure patient portal account using the email address provided. I authorize Sinus and ENT Center of Texas- Tracy Byerly II MD, and its' assignees, including and not limited to its' authorized agents, affiliates, and contractors, to utilize all contact information I have provided to communicate with me. I hereby grant permission and consent Sinus and ENT Center of Texas- Tracy Byerly II MD and its' assignees, including and not limited to its' authorized agents, affiliates, and contractors to communicate with me via phone call, text messaging, portal messages, email, etc.

Initial _____ Date _____

ePrescribing is defined as a physician's ability to electronically send an understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. Sinus and ENT center of Texas- Tracy Byerly II MD PA and its Affiliated Providers, by initialing below you allow us to view your external prescription history via the RxHub service and PDMP. This will provide the physician/physician assistants with information about medications the patient is already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form you are agreeing to allow the Sinus and ENT Center of Texas- Tracy Byerly II MD PA and its Affiliated Providers to request and use your prescription medication history from other healthcare providers, pharmacies, or third-party pharmacy benefit payers for treatment purposes. My signature certifies that I read and understood the scope of my consent and that I authorize access.

Initial _____ Date _____

First Name: _____ Last Name: _____ DOB: _____

No-Show Policy

“No-Shows” have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient “no-show” a scheduled appointment it potentially jeopardizes the health of the “no-showing” patient, it’s unfair (and frustrating) to the other patients that would have taken the appointment slot, and disrespects not only the provider’s time, but also the time of the entire clinic staff.

To avoid getting a “No-Show”

- **Confirm your appointment** –Sinus and ENT Center of Texas will attempt to contact you three business days prior to your appointment to confirm, cancel, or reschedule your appointment.
- **Arrive 10-15 minutes early** –this allows time for completion of your check-in.
- **Give 24-hour notice to cancel or reschedule your appointment** – please be courteous and call us if you are unable to attend. This time can be reallocated to someone who is in urgent need of treatment.
- After three “no-shows” a \$25.00 cancellation/no show fee will be collected prior to rescheduling your next appointment.

After three or more “no-shows” within a one-year period, you may be dismissed from the care of your medical provider.

- If you are dismissed from the care of your medical provider, your remaining scheduled appointments will be cancelled.
- Only emergency medical treatment will be offered within the first 30 days of dismissal.

I certify that I have read the Sinus and ENT Center of Texas’s-Tracy Byerly II MD PA “No Show” policy, understand its’ contents, and agree to the terms outlined above.

Initial _____ Date _____

Consent for Health Information Exchange/HIPPA Release

PRISMA is the health information exchange that brings together records from small clinics/large hospital systems whose medical records participate in the Carequality and CommonWell Health alliance Networks. PRISMA also aggregates patient information from insurance payers and patient’s wearable devices to promote better interoperability and patient health outcomes.

The Sinus and ENT Center of Texas- Tracy Byerly II MD PA will send and receive documents when requested by external connected sites (PRISMA) and display/reconcile them into our electronic medical records. By initialing below, you are giving consent for the Sinus and ENT Center of Texas- Tracy Byerly II MD PA to participate within the PRISMA network on your behalf and allow the external exchange of your personal medical records.

Initial _____ Date _____

The Following individuals are Designated HIPPA approved contacts and may access my medical records when requested:

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____ Phone Number: _____

Relationship to Patient: _____ POA: YES NO

- Medical Information Billing Information Emergency Contact

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____ Phone Number: _____

Relationship to Patient: _____ POA: YES NO

- Medical Information Billing Information Emergency Contact

Printed Name: _____ Signature: _____ Date: _____

First Name: _____ Last Name: _____ DOB: _____

Notice of Endoscope Use Policy

The Sinus and ENT Center of Texas utilizes office endoscopes to diagnose and treat many conditions of the ear, nose, and throat. Our providers may want to perform a nasal or oral endoscopy at the time of your appointment. This is an in-office procedure in which a small sterile camera is used to visualize the nasal cavity, sinuses, throat and vocal cords. Depending upon the nature of your condition, the endoscopy may be diagnostic and used strictly for visualization purposes.

The following are examples of when an endoscope may be used:

- Diagnosis and treatment of chronic sinusitis
- Dysphagia (difficulty swallowing) or globus sensation (feeling like something is stuck in the throat)
- Voice changes
- Collection of nasal or throat specimen for culture
- Evaluation of openings, masses, polyps, or any other cause of blockage
- Evaluate for healing process or assess post-surgical complications
- Biopsy for pathology evaluation
- Debridement- removal of old blood, foreign material, packing, scabs/scar/blockage
- Control of epistaxis (nosebleeds)
- Post cancer removal
- Anything else your provider deems medically necessary

Once you are back in an exam room the provider, nurse, or medical assistant will spray you with medication to prepare for the endoscope. This spray is a combination of Afrin (to shrink tissue) and Lidocaine (to numb the tissue). This medication can be sprayed nasally or orally. It will drain down the back of the throat with can cause oral/throat numbness. Some patients may experience a sensation that they can't swallow – do NOT panic, this means the medication is numbing the appropriate area and will subside shortly.

Insurance companies always consider diagnostic endoscopies a surgical procedure. We are notifying you of this in advance as a courtesy. We do not want you to be surprised when you receive your explanation of benefits. Your insurance company may also reimburse “surgical services” at a different rate than an office visit. If so, those charges may be applied towards your deductible, or a co-insurance amount (additional fee) may be due for the service provided.

By signing below, you are stating that you have read and understand this notice regarding the use of nasal (rigid) and mouth (flexible endoscopies) within our office and are aware that you may be responsible for any additional fees that may occur.

Printed Name

Signature

Date

First Name: _____ Last Name: _____ DOB: _____

Designation of Authorized Adult to consent to Medical Treatment for Minor Patients

I do hereby state and represent that I have legal custody of the above-mentioned minor patient and that I have the authority to consent to all medical/surgical care of said minor. By signing below, I grant my authorization and consent for the Designated Adult(s) listed below to accompany the minor to Sinus and ENT Center of Texas-Tracy Byerly II MD PA locations for medical care and treatment.

I state and confirm that the Designated Adult(s) listed below are at least 18 years of age and competent to make medical decisions on my behalf. I authorize the Designated Adult(s) to consent to all treatment for the minor that is covered under Sinus and ENT Center of Texas-Tracy Byerly II MD PA consent to treat that I have previously signed, including, but not limited to, routine medical examination and treatment, immunizations, counseling, and in rare cases life saving measures.

I agree to assume financial responsibility for all expenses of the minor's medical care authorized by the Designated Adult(s). I understand that the healthcare provider, at his or her discretion, may require a parent or legal guardian to be present for certain non-emergent medical treatments, and in such cases, I may be required to accompany the minor.

I further understand that this authorization does not authorize the Designated Adult(s) to give written consent to the use or disclosure of the minor's protected health information, as those terms are defined by federal law.

I understand that I may change or revoke this authorization at any time by notifying the Sinus and ENT Center of Texas- Tracy Byerly II MD PA in writing.

The following individuals are Designated Authorized Adult(s):

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____ Phone Number: _____

Relationship to Patient: _____

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____ Phone Number: _____

Relationship to Patient: _____

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____ Phone Number: _____

Relationship to Patient: _____

Printed Name:

Legal Guardian Signature:

Date:

First Name: _____ Last Name: _____ DOB: _____

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

DRUG ALLERGIES? YES NO ALLERGIES

Allergies to Medications	Type of Reaction

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: (Prescription, Over the counter, or Herbal)

NO CURRENT MEDICATIONS

I have a list I have provided separately

Medication, Dosage, Frequency	Medication, Dosage, Frequency

Please list *all* your surgical history below:

No Surgical History

Surgery Performed:	Date Performed:

First Name: _____ Last Name: _____ DOB: _____

Medical/Surgical History:

Have you ever been *diagnosed* with any of the following?

No Medical History

<p><u>Cardiovascular:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Coronary Artery Disease<input type="checkbox"/> Elevated Cholesterol<input type="checkbox"/> High Blood Pressure<input type="checkbox"/> Congestive Heart Failure<input type="checkbox"/> Stroke <p><u>Gastrointestinal:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Hepatitis<input type="checkbox"/> Hernia<input type="checkbox"/> Gastroesophageal Reflux <p><u>Ear/ Nose/Throat: (HEENT):</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Cataracts<input type="checkbox"/> Glaucoma<input type="checkbox"/> Chronic Ear Infections<input type="checkbox"/> Hearing Loss<input type="checkbox"/> Chronic Sinusitis<input type="checkbox"/> Nasal Polyps<input type="checkbox"/> Nasal Allergies<input type="checkbox"/> Recurrent Tonsillitis<input type="checkbox"/> Tinnitus<input type="checkbox"/> Vertigo <p><u>Pulmonary:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Asthma<input type="checkbox"/> COPD<input type="checkbox"/> Emphysema<input type="checkbox"/> Sleep Apnea<input type="checkbox"/> Tuberculosis	<p><u>Genitourinary:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Prostate Enlargement<input type="checkbox"/> Kidney Stones<input type="checkbox"/> Renal Failure (Acute) <p><u>Hematologic/Immunologic:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Anemia<input type="checkbox"/> Allergies<input type="checkbox"/> Food Allergies <p><u>Infectious Disease:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Mononucleosis<input type="checkbox"/> STD Type _____ <p><u>Metabolic/Endocrine:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Diabetes<input type="checkbox"/> Hypothyroidism (Thyroid deficiency)<input type="checkbox"/> Hyperthyroidism (Thyroid excess) <p><u>Neoplastic:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Cancer Type _____ <p><u>Neurologic/Psychiatric:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Migraines<input type="checkbox"/> Major Depression<input type="checkbox"/> Anxiety<input type="checkbox"/> Other
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Tobacco Use? YES NO FORMER

Cigarettes: YES NO Packs/Day: _____ Other: _____

Exposed to secondhand smoke? YES NO

Caffeine Consumption? YES NO Type: _____

Have you consumed alcohol in the last year? YES NO

First Name: _____ Last Name: _____ DOB: _____

Sinus Questionnaire

Do you currently suffer from any of the following symptoms? YES NO

- | | |
|---|---|
| <input type="checkbox"/> Bad taste or odor | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Maxillary/cheek pain or pressure | <input type="checkbox"/> Teeth/gum pain |
| <input type="checkbox"/> Frontal pain or pressure | <input type="checkbox"/> Orbital pain or pressure |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Globus sensation |
| <input type="checkbox"/> Green or yellow drainage | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Decreased sense of smell | <input type="checkbox"/> Dizziness |

How Frequently do you have sinus and nasal symptoms?

- Continuously
- This is the first time
- 1-3 times a year
- 4-6 times a year
- More than 6 times a year
 - Constantly
 - Monthly
 - Weekly
 - Daily

Do your symptoms improve between episodes?

- Yes, my symptoms completely resolve
- No, my symptoms never improve
- Sometimes my symptoms improve

In the last year have you been treated with antibiotics?

- No
- Yes, please choose from the following list.
 - Augmentin (Amoxicillin Pot)
 - Cefdinir
 - Levaquin
 - Azithromycin (Z pack)
 - Bactrim
 - Amoxicillin/Penicillin
 - Other _____

Was the infection cleared after 1 round of antibiotics?

- Yes
- No, what was your second round of antibiotics?
 - Augmentin (Amoxicillin Pot)
 - Cefdinir
 - Levaquin
 - Azithromycin (Z pack)
 - Bactrim
 - Amoxicillin/Penicillin
 - Other _____

Have you tried nasal irrigations/lavage? YES NO

If yes, how long have you been irrigating?

- 1-2 weeks
- 2-4 weeks
- 6 weeks or longer

In the last year, were steroids prescribed for the treatment of allergy, sinusitis, or asthma?

- No
- Yes, please choose from the following list:
 - Prednisone
 - Dexamethasone
 - Medrol
 - Orapred

Have you ever had a CT sinus scan?

- No
- Yes, please provide details (include dates)

Have you ever had sinus or nasal surgery?

- No
- Yes, please provide details (include dates)

First Name: _____ Last Name: _____ DOB: _____

Allergy Questionnaire

Do you suffer from any of the following symptoms? YES NO

- | | |
|--|---|
| <input type="checkbox"/> Sneezing fits | <input type="checkbox"/> Itchy throat |
| <input type="checkbox"/> Itchy ears | <input type="checkbox"/> Scratchy roof of mouth |
| <input type="checkbox"/> Itchy watery/eyes | <input type="checkbox"/> Postnasal drip |
| <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Eczema flares |
| | <input type="checkbox"/> Hives |

Please list any previous medications that you have tried for your allergy symptoms that were UNSUCCESSFUL:

- | | |
|--|---|
| <input type="checkbox"/> Claritin (Loratadine) | <input type="checkbox"/> Nasonex (Mometasone) |
| <input type="checkbox"/> Allegra (Fexofenadine) | <input type="checkbox"/> Flonase (Fluticasone propionate) |
| <input type="checkbox"/> Zyrtec (Cetirizine) | <input type="checkbox"/> Ipratropium Bromide |
| <input type="checkbox"/> Xyzal (Levocetirizine) | <input type="checkbox"/> Astelin (Azelastine-Hydrochloride) |
| <input type="checkbox"/> Singulair (Montelukast) | <input type="checkbox"/> Dymista |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Patanol (Olopatadine) |
| <input type="checkbox"/> Mucinex | <input type="checkbox"/> Ketotifen (Alaway, Zaditor) |

When are your allergy symptoms most apparent?

- Spring
- Summer
- Fall
- Winter
- All year

Have you ever been Allergy tested?

- Never
- I had blood testing.
- I had skin testing.

If yes, how many years ago?

Did you receive immunotherapy? Yes NO

- Allergy Shots for _____ years
- Sublingual therapy
- Declined treatment.

Do you have asthma? Yes No

If yes, what do you take to control your asthma?

- Asthma inhalers
- Nebulizer treatments
- Oral steroids
- Theophylline
- Fasentra
- Dupixent
- Xolair
- Nucala

Did immunotherapy help with your symptoms?

- Never
- Yes, they helped me a great deal.
- Yes, they somewhat helped me.
- Yes, they did NOT help me

Do you suffer from hearing loss or tinnitus?

- Yes
- No

Have you had a hearing test in the last year?

- Yes
- No