PATIENT REGISTRATION FORM

PATIENT INFORMATION: **PLEASE PRINT CLEARLY** DATE: _____

First Name_____ MI_____ Last Name_____ Age_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone _____ Date of Birth_____ Sex _____

Marital Status: M D S W Occupation_____ Social Security #_____

Circle One: Employed, Student - Full-time/Part-time

Insurance:_____ Referred By:_____ Family Physician:_____

RESPONSIBLE PARTY: (if other than patient)

First Name_____ M.I.____ Last Name _____

Address _____

City_____ State_____ Zip Code _____

Home Telephone_____ Work Telephone_____ Marital Status _____

Date of Birth_____ Sex _____ SS # _____

Spouse's Name_____ Work Phone: _____

Contact in Case of Emergency:_____ Day Phone: _____

INSURANCE INFORMATION:

Primary Insurance Company _____

Group # _____ Policy #_____

Insured's Name _____ DOB: _____ Sex: M F

Patient's Relationship to the Insured (circle one): Self/Spouse/Child/Other

Secondary Insurance Company _____

Group # _____ Policy #_____

Insured's Name _____ DOB: _____ Sex: M F

Patient's Relationship to the Insured (circle one): Self/Spouse/Child/Other

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

Company Name _____

Company Address_____

City_____ State_____ Zip Code _____

Company Telephone #_____ Extension # _____

Insurance Authorization and Assignment

I hereby authorize **Yasmeen Jalal, M.D., P.A.** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or any dependents. I understand that I am responsible for any amount not covered by insurance or as provided by HMO or PPO contracts.

DATE_____ SIGNATURE _____

TX Driver's License #:_____

OFFICE USE ONLY:

Notes _____

_____

_____

Initials _____

Dr. Yasmeen Jalal

Town Center ENT

Patient Name:_____ **Patient DOB:**_____

List Current Medications

List Drug Allergies

X_____ _____

Patient or Guardian signature *Date*

TOWN CENTER ENT
3521 TOWN CENTER BLVD SOUTH, SUITE B SUGAR LAND, TX-77479
YASMEEN JALAL, M.D.

Designation and Direction for Release of Medical Information

I _____ (Patients Name) hereby authorize my protected health information to be discussed / disclosed as necessary to the person named bellow as required for my medical treatment.

Signed: _____

Date: _____

Witness: _____

Personal Representative is: _____

Relationship to the patient: _____

In Addition

[] It is permitted to leave message on my answering machine regarding my appointment.

[] It is permitted to leave message on my answering machine regarding my lab results.

[] It is permitted to leave message on my answering machine regarding my medical records.

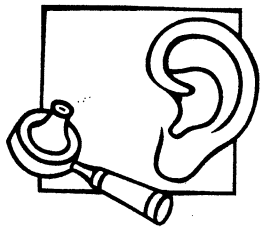
[] It is permitted to leave message with the person above regarding my appointment.

[] It is permitted to leave message with the person above regarding my lab results.

[] It is permitted to leave message with the person above regarding my medical records.

[] It is not permitted to leave message regarding my medical records with anyone other than me.

TOWN CENTER ENT
3521 TOWN CENTER BLVD SOUTH, SUITE B SUGAR LAND, TX-77479
YASMEEN JALAL, M.D.



PRIVACY POLICY

In order to continue to provide you with the quality care you have became accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purposes of **treatment, payment**, and **operations** (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy & Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Specifically, we will need to disclose your private information under the following circumstances:

- **Sharing information for the purpose of treatment:** We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you quality care and the educational/wellness programs specified in your insurance plan.
- **Sharing of information for the purpose of payment:** We will share all necessary information with your insurer(s), payor(s), government entities (such as Medicare, Medicaid, etc.), and their representatives (including, but not limited to) benefit determination and utilization review as well as representatives and billing companies.
- **Sharing information for purpose of operations:** We will share information necessary for ongoing operations of this office, including (but not limited to) credentialing process, peer review, accreditation, and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your signature indicates your consent has been given freely. You understand that you may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Name
(printed)_____

Patient's Signature:_____

Date Signed:_____

Town Center ENT Clinic

Dr. Yasmeen Jalal M.D P.A.

New Patient Insurance Verification Form

Tax ID#760533483

Appt. Date:_____ Acct.#_____ Referring Physician:_____

Patient Name:_____ DOB: _____ SS#_____

Address: _____City:_____ State:_____ Zip:_____

Phone#( )_____ Alt#( )_____ Wk Ext____/ Cel

Reason for visit:_____

Insurance Co._____ Phone#( )_____

Claims Mailing Address: PO Box_____ City: _____ State:_____ Zip:_____

Insured'sName:_____DOB:_____Insured's SS#_____

Group#_____ ID#_____

Coverage Type:_____ Effective Date:_____ Pre-Existing_____

Co-Pay:_____ Deductible:_____ Amount Met: _____ Co-Ins:_____

OOP:_____ Amount Met: _____ Lifetime Max.:_____

Hearing test covered: Y / N by: CP / DED In Office Procedure covered: Y / N by: CP / DED

* If HMO PCP:_____ Phone #:_____ Ref Req.: Y / N

Contracted Labs:_____

Verified With:_____ Verified by:_____

Amount to collect:_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION: **PLEASE PRINT CLEARLY** DATE:_____

First Name_____ MI_____ Last Name_____ Age_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work Phone _____ Date of Birth_____ Sex_____

Marital Status: M D S W Occupation_____ Social Security # _____

Circle One: Employed, Student - Full-time/Part-time

Insurance:_____ Referred By:_____ Family Physician: _____

Have you been to see us before? ☐ Yes ☐ No

Has anyone in your family been treated by our physicians? ☐ Yes ☐ No ☐ Who:_____ Relationship _____

Please state in your own words what your **EAR, NOSE** or your **THROAT** problem is:_____

List drug allergies:_____ Is your health generally (circle one): **Good** **Fair** **Poo**

List ALL medications, drops, sprays you are using: _____

For Children - Are immunizations current? ☐ Yes ☐ No

Are you pregnant now? ☐ Yes ☐ No months_____ How much do you smoke, if any?_____ Alcohol? _____

List ALL operations you have **EVER** had: _____

List ALL serious illnesses: _____

Circle problems you have **NOW** or have had in the **PAST**:

1. Ear Diseases or Infections
2. Hearing Loss
3. Ringing/Noises in the Ears
4. Vertigo/Dizziness
5. Loss of Balance
6. Nasal Problems/Blockage
7. Sinus Problems
8. Allergy/Hay Fever
9. Allergy Shots Taken
10. Throat or Neck Problems
11. Swallowing Problems
12. Eye Problems
13. Heart/Circulation Problems
14. High Blood Pressure
15. AIDS
16. Lung Problems or Asthma
17. Shortness of Breath
18. Stomach/Intestinal Problems
19. Kidneys/Bladder/Reproductive
20. Muscles/Joints/Bone Problems
21. Neurologic or Mental Problems
22. Skin Problems
23. Blood Problems/Easy Bleeding
24. Tumors or Cancer
25. Other (List Please)

Explain: _____

Who in your immediate family has had: Heart Disease_____ TB_____ Asthma_____ Cancer_____ Hearing Loss _____

Hx. & P.E. _____

EARS: PINNA _____ EXT. MEATUS. _____

CANALS (R)_____ T.M. (R) _____

(L)_____ (L) _____

FORKS 256 R ___|___ L ( ) 512 R ___|___ L ( ) 2048 R L

NOSE: EXT._____ SEPTUM _____

TURBINATES _____ AIRWAY_____ EXUDATE _____

ORAL:_____ TEETH _____

THROAT: PALATE_____ TONSILS _____ N.P./ADENOIDS _____

LARYNX _____ PHARYNX _____ TMJ _____

PTERYGOIDS_____

NECK: _____

NEUROL: _____

X-RAY: _____

AUDIO: _____

IMPRESSION: _____

RX: _____

RETURN: _____