



Christine Gilliam, M.D.  
 21738 Hardy Oak Blvd. Ste. 103  
 San Antonio, TX 78258  
 Tel. (210) 647-3838  
 Fax (210) 403-3166  
 www.everyonesent.com

**PATIENT DEMOGRAPHICS AND HEALTH HISTORY**

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_ cell/home/other  
 Patient SS#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Guarantor (if pt a minor): \_\_\_\_\_ Phone: \_\_\_\_\_ cell/home/other  
 Guarantor SS/DOB#: \_\_\_\_\_ / \_\_\_\_\_ Insurance Policy Network: \_\_\_\_\_  
 Insurance ID/Policy #: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_  
 Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Pharmacy and City: \_\_\_\_\_

**PAST HEALTH**

Do you now or have you had any of the following problems? **CANCER:** Type \_\_\_\_\_ Date: \_\_\_\_\_  
 Asthma Yes or No **Are you pregnant or trying to become pregnant?**  
 Heart Disease Yes or No Yes or No  
 High Blood Pressure Yes or No  
 Prior Heart Attack Yes or No **OTHER IMPORTANT ISSUES:** \_\_\_\_\_  
 Bleeding Disorder Yes or No \_\_\_\_\_  
 Facial Injury Yes or No \_\_\_\_\_  
 Diabetes Yes or No \_\_\_\_\_  
 AIDS/HIV positive Yes or No \_\_\_\_\_  
 Snoring Yes or No \_\_\_\_\_

**SURGICAL HISTORY**

Have you had any problems with anesthesia? No Yes  
 If yes, please list what sort of problems \_\_\_\_\_  
 Have you ever had prolonged bleeding after surgery? No Yes  
 Have you ever had any of the following SURGERIES? No If YES mark any of the following you have had.  
 Ear Tubes \_\_\_\_\_ Date: \_\_\_\_\_ Adenoidectomy \_\_\_\_\_ Date: \_\_\_\_\_  
 Ear Surgery \_\_\_\_\_ Date: \_\_\_\_\_ Tympanoplasty \_\_\_\_\_ Date: \_\_\_\_\_  
 Mastoidectomy \_\_\_\_\_ Date: \_\_\_\_\_ Heart Bypass \_\_\_\_\_ Date: \_\_\_\_\_  
 Septoplasty \_\_\_\_\_ Date: \_\_\_\_\_ Heart Stent \_\_\_\_\_ Date: \_\_\_\_\_  
 Sinus Surgery \_\_\_\_\_ Date: \_\_\_\_\_ Tracheostomy \_\_\_\_\_ Date: \_\_\_\_\_  
 Thyroidectomy \_\_\_\_\_ Date: \_\_\_\_\_ Transplant Surgery \_\_\_\_\_ Date: \_\_\_\_\_  
 Tonsillectomy \_\_\_\_\_ Date: \_\_\_\_\_ Splenectomy \_\_\_\_\_ Date: \_\_\_\_\_  
 Other Surgery \_\_\_\_\_ Date: \_\_\_\_\_ Other Surgery \_\_\_\_\_ Date: \_\_\_\_\_

Is there a family history of the following:  
 Bleeding disorders \_\_\_ No \_\_\_ Yes If yes, which family member \_\_\_\_\_  
 Allergies \_\_\_ No \_\_\_ Yes If yes, which family member \_\_\_\_\_  
 Anesthesia Problems \_\_\_ No \_\_\_ Yes If yes, which family member \_\_\_\_\_

Do you currently smoke? No Yes # of years \_\_\_\_\_ Ave. Packs/Day \_\_\_\_\_  
 Are you a former smoker? No Yes Second hand smoke history: \_\_\_None \_\_\_Currently exposed  
 Alcohol usage? \_\_\_None\_\_\_Occasionally\_\_\_Daily Use recreational drugs? \_\_\_Yes\_\_\_No

Are you taking ANY medication right now? (This includes prescription and over-the-counter medications)

No  Yes If yes, please list below.

Medication	Medication	Medication

Are you ALLERGIC to ANY MEDICATION?  No  Yes If yes, please list below.

Name of Medication	Type of Reaction

Are you allergic to Latex? \_\_\_No \_\_\_Yes

Are you allergic to Lidocaine? \_\_\_No \_\_\_Yes

REVIEW OF SYSTEMS

**CIRCLE** any problems you have or had recently in the following areas:

**General:** Appetite Loss, Chills, Fatigue, Fever, Night Sweats, Weight Gain, Weight Loss

**Skin:** Change in Wart/Mole, Dryness, Hair Loss, Hives, Itching, Rash, Skin Color Changes

**HEENT:** Blurred Vision, Excessive Tearing, Eye Pain, Eye Redness, Hearing Loss, Decreased Hearing, Ear Discharge, Ear Pain, Ringing in the Ears, Nose Bleed, Nasal Congestion, Hoarseness and Voice Changes

**Neck:** Neck Mass, Neck Pain, Neck Stiffness, Swollen Glands

**Respiratory:** Cough, Difficulty Breathing, Snoring, Wheezing

**Cardiovascular:** Chest pain, Difficulty Breathing Or Exertion, Fainting/Blacking Out, Palpitations, Shortness of Breath

**Gastrointestinal:** Abdominal pain, Hematemesis, Heartburn, Nausea, Vomiting

**Musculoskeletal:** Muscle pain, Muscle Weakness

**Neurological:** Fainting, Headaches, Incoordination/Falls, Seizures, Spinning Sensation, Unusual Sensation, Weakness,

**Psychiatric:** Anxiety, Change in Sleep Pattern

**Endocrine:** Excessive Thirst

**Hematology:** Abnormal Bleeding, Easy Bruising, Enlarged Lymph Nodes, Pinpoint Hemorrhages

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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#### **OFFICE POLICY ON PAYMENT:**

It is our policy to require payment on all patient responsibilities for any office charges at the time of service.

#### **CANCELLATION POLICY:**

Office visits cancelled or rescheduled within 48 hours and/or two business days prior to scheduled appointment will result in \$25.00 cancellation fee.

Audiology visits cancelled or rescheduled within 48 hours and/or two business days prior to scheduled appointment will result in \$50.00 cancellation fee.

Surgery and procedures cancelled or rescheduled within FIVE business days prior to scheduled appointment will result in \$50.00 cancellation fee.

#### **INSURANCE POLICY:**

It is the goal of the Physicians at Everyone's ENT & Sinus Center to offer you the best treatment plan based on the most accurate diagnosis. To obtain the diagnosis, our providers may recommend procedures or tests to be performed during your visit including but not limited to scopes into your nose and/or throat, hearing tests, allergy testing, CT scan.

Additional diagnostic procedures and tests are not included in a routine office visit and will result in additional charges. You are financially responsible for charges that may be billed to you as a result of any diagnostic procedures/tests performed. Depending on your specific benefit plan the procedure/test charges may be applied to an annual deductible or coinsurance.

Insurance provides reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. In addition, accounts you are considered a guarantor for will also be paid with any credit on the account prior to a refund being issued.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize the release of any medical information necessary to process claims and I permit a copy of this authorization to be used in place of an original. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I hereby authorize Everyone’s ENT & Sinus Center to apply for benefits on my behalf for covered services and request that payment from my insurance company be made directly to Christine Gilliam M.D., P.A.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to Christine Gilliam M.D., P.A. to apply to my account, should a balance exist.

For your convenience, we accept payment methods: cash, debit card, major credit cards and Care Credit.

**I have read the above and accept financial responsibility in full for this account.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Patient, Parent, or Guardian (please circle)



**IN CASE OF EMERGENCY PLEASE CONTACT:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Our office is dedicated to maintain the privacy of your Protected Health Information. This includes such data as your name, address, phone number, date of birth, Social Security number, account information, medical record number, or any other unique identifying number. In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my Protected Health Information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

I authorize Everyone's ENT & Sinus Center to **RELEASE** copies of my records TO:

\_\_\_\_\_  
Name of Physician or Institution, etc.

\_\_\_\_\_  
Address (Please FULLY complete!)

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Phone Number FAX Number

\_\_\_\_\_  
Dates of treatment for which you need records

**\*\*\*PLEASE CHECK ALL THAT APPLY:**  
**Information to be RELEASED:**  
 Office Notes  Pathology  
 Audiograms  CT Sinus Scans  
 Labs  U/S Thyroid  
 Allergy Testing  
 Other: \_\_\_\_\_

I authorize Everyone's ENT & Sinus Center to **OBTAIN** copies of my records FROM:

\_\_\_\_\_  
Name of Physician or Institution, etc.

\_\_\_\_\_  
Address (Please FULLY complete!)

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Phone Number FAX Number

\_\_\_\_\_  
Dates of treatment for which you need records

**PLEASE SEND REQUESTED RECORDS TO:**  
**ATTENTION MEDICAL RECORDS**  
**Everyone's ENT & Sinus Center**  
**21738 Hardy Oak Blvd. Suite 103**  
**San Antonio, TX 78258**  
**Tel.: (210)647-3838 Fax: (210-403-3166**

**Information will be used / disclosed for the following purpose(s):**

Continuation of Care (for another Provider)  Pending Appointment Date: \_\_\_\_\_

Personal Use  Other: \_\_\_\_\_

**The patient or the patient's representative MUST read and initial the following statements:**

- 1. I understand that my health care will not be affected if I do not sign this form.
- 2. I understand that I may revoke this authorization at any time, in writing, by notifying our office at:  
Everyone's ENT & Sinus Center, 21738 Hardy Oak Blvd. Ste. 103, San Antonio, TX 78258. Phone: (210) 647-3838. If I do revoke the Authorization, it will not have any effect on any actions taken by Everyone's ENT & Sinus Center prior to their receipt of the Revocation.
- 3. Unless otherwise noted, I understand this authorization **WILL EXPIRE** when ALL REQUESTED RECORDS have been transferred OR when a period of NINETY DAYS has transpired.
- 4. I understand that routine requests may take up to 15 business days to process.
- 5. I understand that my records may be faxed or mailed via United States Post Office.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's representative

\_\_\_\_\_  
Relationship to Patient



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*Receipt of Notice of Privacy Practices Written Acknowledgement Form*

I, \_\_\_\_\_, have been offered a copy of

(Patient Name Printed)

**Everyone's ENT & Sinus Center's Notice of Privacy Practices.**

\*

\_\_\_\_\_

Signature of Patient/Parent or Guardian

\_\_\_\_\_

Date

A copy of the HIPPA regulations can be found in the black folder at the front desk window. A copy can also be found on our website for your review. Please review it at your leisure. Please ask the front desk receptionist for a copy if you desire one to take home.