REGISTRATION FORM

(Please Print)

Today's date: _____/_____/_____

PATIENT INFORMATION

Last name:	First:	Middle Initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Gender: ☐ M ☐ F
Preferred Name:	☐ Married ☐ Single ☐ Divorced ☐ Widowed		Birth date: / /	Age:
Primary address:			SSN:	
City:	State:	ZIP Code:	Home / Cell:	
Spouse/Parent Name:			Spouse/Parent #:	
Your Email:			Spouse/Parent DOB:	

Indicate race: ☐ American Indian ☐ African American ☐ Asian ☐ White ☐ Multiracial ☐ Other _____

Indicate Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer Name: Employer Phone:

Referred to clinic by (please check one box):

☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to me ☐ Internet ☐ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative: Birth Date: / /

Relationship to patient: Phone #:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: SSN (responsible party):

Birth date: / / Phone #:

Is this person a patient here? ☐ Yes ☐ No

Insurance Name: Member #: Group:

Policy Holder name: Birth date: / /

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of secondary insurance: Member #: Group #:

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

I authorize the physician(s) of North Texas ENT to treat me. I authorize any physician/agent of North Texas ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of North Texas ENT. I authorize any physician/agent of North Texas ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay the medical benefits directly to the physician(s) of North Texas ENT. I understand that I am financially responsible for any balance. I agree that a photocopy of this agreement will be considered the same as the original.

Patient/Guardian signature _____ Date _____

Insurance Disclaimer

Dr. Brent A. Metts

I, (print name of patient/guarantor) _____, understand that if my insurance does not pay for my office visit, or any services performed in the office, I will be responsible for any or all procedures.

Please be aware!!!

***Please be aware** that when a patient requires a visit to a specialist, there are diagnostic procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as "in-office procedures/surgeries". The possible procedures which often are performed in this practice during your visit may include, but are not limited to:

Nasal Hemorrhage Control
Tympanostomy/Myringotomy
Nasal Endoscopy with/without Debridement
Audio- Comprehensive
Laryngoscopy
Tympanometry
Otoacoustic Emissions
Complete Endoscopic Exam
Cerumen (ear wax) Removal
Binocular Microscopy
Foreign Body Removal
Nasopharyngoscopy with Endoscope
Epley

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office copay, such as your deductible and/or co-insurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives and processes the claim. Therefore, any quote for services will be considered an estimate and any payment will be considered a partial payment until the insurance company has processed your claim. Your insurance is a contract between you and your insurance carrier; payment is ultimately your responsibility. Payment will be mandatory the day of your appointment, we do not do payment plans and we will not wait until after insurance processes your claim to bill you. We here at Dr. Brent A. Metts' office feel that it is very important for you to know and understand your coverage.

Patient/Guardian Signature_____Date____/_____/_____

Dr. Brent A. Metts' Office Financial Policy

In order to make your experience with us a positive event, please review the following policies of our office.

1. We accept the following: Credit Cards, Debit Cards, Care Credit and cash.
2. We also accept checks, however a $30.00 fee will be charged if returned or canceled and you will not be able to see the doctor until all charges are paid for in-full.
3. This office accepts most insurance plans. If we do not accept your insurance, you are welcome to privately pay for your visit (with the exception of Medicaid) and services performed during your visit. Otherwise, your full amount of the copay, deductible or co-insurance is to be paid in-full at the time of service.
4. We will submit the office visit and any procedures/surgeries done to insurance, but **the patient will be responsible for any and all charges not covered by the insurance company**.
5. Medicare assignments are also accepted here and we will be happy to file for you... however, it is the patient/guarantor's responsibility to make sure it automatically crosses over to your secondary insurance carrier if you have more than one health insurance.
6. In order to ensure prompt payments from your insurance, it is important that you (the patient/guarantor) inform this office of all changes with providers, new insurance cards and any changes in your coverage. Otherwise, you may be charged the full amount for services rendered. Please be sure to update each year, along with your medication list and any allergies that may have changed since your previous visit.
7. Please be aware that the office of Dr. Brent A. Metts reports unpaid bills to a Collection Agency. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account. Any patient sent to collections forfeits any future appointments.

ATTENTION

A $30.00 fee will be charged for each of the following events:

1. Completion of **ANY FORMS** (i.e. FMLA paperwork, Disability forms, other forms to be completed by the doctor, or copies of financial or medical records).
2. Not showing up for appointment, or appointments **NOT** canceled **PRIOR** to the appointment arrival time. We are committed to making you an appointment at your earlier convenience; likewise, we request a courtesy call in advance if you are unable to keep your appointment to allow other patients to be seen. A $30.00 may apply if such notice is not received. Multiple missed appointments may result in our request for you to find another specialist.

We thank you for helping us make this office more efficient for you. Please sign & date below. Your signature states that you agree and will be in compliance with the above policies.

Thank you, office of Dr. Brent A. Metts.

Signature _____ Date _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of birth: ____/_____/____

Release of Information

__ I authorize the release of information including the diagnosis, records; examination rendered to me and the claims information. This information may be released to:

Relation_____Name_____Phone#_____

Relation_____Name_____Phone#_____

Relation_____Name_____Phone#_____

Relation_____Name_____Phone#_____

____ Information is not to be released to anyone except the doctor

TO ANY PHYSICIAN, HOSPITAL, CLINIC OR THEIR REPRESENTATIVE

You are hereby authorized and requested to deliver and furnish to:

Dr. Brent A. Metts

7801 Lakeview Pkwy, Suite 120, Rowlett, TX 75089

972-475-9151 - Fax: 972-475-1757

__Date: _____to_____ OR ____ all past, present and future periods

Signed: _____ Date: ____/_____/____

Consent for Text (SMS) Messaging

With your consent, North Texas ENT would like to send text (SMS) messages to your mobile number.

By providing your informed consent where indicated, you acknowledge that you have understood the information below and agree to participate in our text (SMS) messaging service.

Purpose and Description: North Texas ENT's text (SMS) messaging service is designed to provide you with helpful information, reminders, and notifications via text messages sent to your mobile phone. We may use text (SMS) messages to communicate with you for a variety of purposes, including:

- Appointment reminders
- Missed appointment notifications
- Office closures

☐ I consent to receiving text (SMS) messages from North Texas ENT

_____
Mobile number

☐ I do NOT consent to receiving text (SMS) messages from North Texas ENT

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Name Relationship to Patient

Brent A. Metts, M.D., PhD.
7801 Lakeview Parkway, Suite 120
Rowlett, Texas 75088
972-475-9151

Patient Name_____ Age _____ Height _____ Weight_____

Family Doctor _____ Referring Doctor _____

List all allergies you have to medications: _____

_____

FAMILY HISTORY OF - (Please check if yes):

High Blood Pressure _____ Diabetes _____ Heart Disease _____

Thyroid _____ Epilepsy _____ Cancer _____

Hearing Loss _____ Lung Disease _____ Skin Disease _____

Other (Please specify) _____

SOCIAL HISTORY - (Please check if you use or have used any of the following items daily or frequently):

Tobacco _____ Alcoholic Beverages _____

Have you ever been tested for HIV (AIDS)? If yes, explain _____

Have you ever been allergy tested? _____ Skin test _____ Blood test _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS (Please check if yes)

Peptic Ulcers _____ Thyroid Problem _____ Lung Disease _____ Cancer _____

Earache _____ Headache _____ Dizziness _____ Nose Bleed _____

High Blood Pressure _____ Diabetes _____ Heart Disease _____ Skin Disease _____

TB _____ Sleep Apnea _____ Sinusitis _____ CPAP _____

Hearing Loss _____ Seizures _____ Snoring _____ Allergies _____

Other (Please specify) _____

What problems brought you to the office? _____

_____

How long have you had these problems? _____

For women: Is there a possibility you might be pregnant? _____ Are you taking birth control pills? _____

Must be completed

before you can see the doctor:

Name: _____ Date: _____

Please call HM#_____ CELL#_____

What pharmacy do you (the patient) use?

Name: _____ Phone #: _____ Location:_____

Who is your (the patient) primary physician?

Name: _____ Phone #: _____

Address: _____

Latex Allergy? (PLEASE CHECK ONE) □Yes □No

Surgeries:_____

_____

_____

_____

Medications:_____

_____

_____

_____

_____

_____

Do you have any of the following symptoms **right now**? Please check all that apply.

Name:_____ **Date:**_____ **Height:**_____ **Weight:**_____

[General]
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Body Aches
- ☐ **None of the above**

[HEENT]
- ☐ Blurred vision
- ☐ Snoring
- ☐ Double vision
- ☐ Hearing loss
- ☐ Ear pressure/fullness
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Ear Swelling
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Runny nose
- ☐ Nasal Obstruction
- ☐ Nose Bleed
- ☐ Nose/Sinus Pain
- ☐ Sinus/Facial Pressure
- ☐ Trouble swallowing
- ☐ Lump in Throat
- ☐ Hoarseness
- ☐ Throat Clearing
- ☐ Oral ulcers/Spots
- ☐ Enlarged tonsils
- ☐ Sore Throat
- ☐ Thyroid Mass
- ☐ Neck Mass
- ☐ Loss of smell or taste
- ☐ **None of the above**

[Cardio]
- ☐ Chest pain
- ☐ Irregular beats
- ☐ Syncope
- ☐ **None of the above**

[Respiratory]
- ☐ Chronic cough
- ☐ Cough
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Apneas
- ☐ **None of the above**

[GI]
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Vomiting
- ☐ **None of the above**

[GU]
- ☐ Possible Pregnancy
- ☐ Trouble Urinating
- ☐ **None of the above**

[Integ]
- ☐ Contact Allergy
- ☐ Dry skin
- ☐ Itching
- ☐ Rash
- ☐ Skin Lesion
- ☐ **None of the above**

[Endo]
- ☐ Sensitive to Cold
- ☐ Sensitive to Heat
- ☐ Hair loss
- ☐ **None of the above**

[Immuno]
- ☐ Sinus allergies
- ☐ Dermatitis
- ☐ **None of the above**

[Psych]
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ **None of the above**

[Neuro]
- ☐ Poor Concentration
- ☐ Poor Memory
- ☐ Seizures
- ☐ Headache
- ☐ Numbness
- ☐ Fainting
- ☐ Tingling
- ☐ Dizziness
- ☐ Weakness
- ☐ **None of the above**

[Muscul]
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ **None of the above**

[Heme]
- ☐ Easy bleeding
- ☐ Easy Bruising
- ☐ Lymph Nodes
- ☐ **None of the above**

Are you on hospice? ☐ **Yes** ☐**No**

_____

Initial Here