

DANNY WONG, MD, PA
4201 Garth Rd. Ste. 321
Baytown, TX 77521

DATE _____

PATIENT INFORMATION

NAME _____

MAILING ADDRESS _____
LAST FIRST MI

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DOB _____ SSN _____ SEX M F MARITAL STATUS _____

EMPLOYER _____ WK. PHONE _____ CELL PHONE _____

STUDENT STATUS OF PATIENT FT PT N/A

GUARANTOR INFORMATION (guarantor is the person whose employer carries insurance)

IS GUARANTOR INFORMATION THE SAME AS PATIENT INFORMATION? YES NO

IF YES SKIP THIS SECTION, IF NO PLEASE COMPLETE:

NAME OF GUARANTOR _____

DOB _____ SSN _____ RELATIONSHIP TO PATIENT _____
LAST FIRST MI

EMPLOYER _____ MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

INSURANCE INFORMATION

NAME OF INSURANCE _____ PHONE # _____

ID# _____ GROUP# _____

DO YOU HAVE SECONDARY COVERAGE? YES NO IF YES: INSURANCE NAME _____

IN CASE OF EMERGENCY NOTIFY (must list contact)

NAME _____ RELATION _____ PHONE _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

WHO IS YOUR PRIMARY PHYSICIAN? _____ DID HE/SHE REFER YOU? YES NO

PHARMACY NAME _____ PHONE _____

I HAVE READ THE DANNY WONG, M.D., P.A. FINANCIAL POLICY ON THE REVERSE SIDE OF THIS FORM, AND I AGREE TO BE BOUND BY ITS TERMS. I UNDERSTAND THAT BY SIGNING THIS FORM I AM ACCEPTING FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR THE ABOVE LISTED PATIENT.

SIGNATURE OF PATIENT OR GUARDIAN

RELATION TO PATIENT

DATE

Financial Policy of Danny Wong M.D.

We at DANNY WONG M.D., P.A. are committed to providing you with the best possible medical care. If you have medical insurance, we will endeavor to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. Please read the following outline carefully and if you have any questions do not hesitate to ask.

Payment for services is due at the time services are rendered unless special arrangements have been made in advance. If you have medical insurance coverage, we will file any and all services rendered to your primary insurance only. You will be responsible for all co-payments, deductibles and/or co-insurance amounts at the time services are rendered. We accept cash, checks, VISA and MASTERCARD. We utilize POSITIVE PAY CHECK SYSTEMS in which all checks presented as payment will be submitted electronically and the amount of the check is electronically debited from your account at the time the check is presented. If your check is denied for payment, an alternate form of payment must be used. There is a \$25.00 charge for all returned checks.

Due to the increasing number of patients who “no show” for appointments a \$50.00 fee will be charged for broken appointments. We ask that patients kindly give 24 hour notice if unable to attend a scheduled appointment to avoid this fee.

You must realize however that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract
- Our fees are generally considered to fall within the acceptable range by most companies, and therefore covered up to the maximum allowance determined by each carrier. This applies only to companies with a percentage (such as 50% or 80%) of UCR. UCR is defined as usual, customary and reasonable by most companies. This statement does not apply to insurance companies who reimburse based on an arbitrary “schedule” of fees which bears no resemblance to the current standard and cost of care in this area.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Filing of insurance claims is a courtesy that we extend to our patients; however, all charges are ultimately your responsibility from the date the services are rendered. We realize that temporary financial difficulties may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have questions about the above information outlining the financial policy of DANNY WONG M.D., P.A. or regarding your insurance coverage, please do not hesitate to ask. We are here to help!

By signing on the reverse side, I understand and agree to the financial policy of DANNY WONG M.D., P.A., and I assign to DANNY WONG M.D., P.A. the benefits payable by my insurance company for the treatment rendered to myself and/or dependants. Your signature also authorizes the release of any and all information to submit claims for benefits, services rendered or services to be rendered for yourself and/or dependants without obtaining your signature on each and every claim to be submitted. Your signature also acknowledges your understanding that you are ultimately responsible for all charge not covered by your insurance company.

In Office Surgical Procedures

There are some procedures that are done in the office that are considered “surgery” by the insurance carriers including Medicare. Some examples of these “surgical procedures” include removal of wax and various uses of scopes within this office, including flexible laryngoscopy, nasal endoscopy, and nasopharyngoscopy. These procedures are often an additional charge to the office visit, and may appear on your bill as such. Surgical procedures may go toward your deductible and may involve more than a co-pay, if your insurance warrants.

I understand that office procedures are an additional surgical procedure and agree to the financial responsibility for procedures if performed.

Patient or guardian signature _____ Date _____

Danny Wong MD, PA

Patient Name: _____

Date of Birth: _____

Authorization For Release of Protected Health Information

Please list anyone who you would like to have access to your medical information. You do not need to list your referring physician but any others (example: family members, friends, employers, caretakers). This information may include your diagnosis, treatment plan, prognosis, test results, appointments and/or billing information.

If you do not want your information to be released to anyone, please leave blank.

Name: _____ Relationship _____

Phone: _____

Name: _____ Relationship _____

Phone: _____

Name: _____ Relationship _____

Phone: _____

It is often necessary to release some personal, health and/or diagnostic information for purposes such as: to schedule diagnostic tests/surgical procedures, to contact you in regards to scheduled appointments by US mail or telephone, to keep your referring physician informed of your condition, and/or to refer you to another physician or facility for services. Please mark the appropriate box below if you do or do not authorize your information to be released in the manner stated above.

Yes, I do agree No, I do not agree

Acknowledgement of Notice Privacy Practices

By signing below I am acknowledging that I have reviewed and agree to this office's Notice of Privacy Practices (posted in waiting room, exam rooms, and available if you would like a copy for your records) which explains how my medical information will be used and disclosed. I also understand that I may revoke this authorization, in writing, at any time by contacting the HIPPA Privacy Officer at this office.

Signature of Patient, Parent, or Legal Guardian

Date

ENT PATIENT HEALTH HISTORY

DATE _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.**

Full Name _____ **Date of birth** _____ **Age** _____

Male Female- Could you possibly be pregnant? Yes No Are you breastfeeding? Yes No

What is the main reason you are seeing the doctor today? _____

REVIEW OF SYSTEMS: check any symptoms you have recently experienced.

<p>CONSTITUTIONAL</p> <input type="checkbox"/> chills <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> night sweats	<input type="checkbox"/> nasal congestion <input type="checkbox"/> runny nose <input type="checkbox"/> postnasal drainage <input type="checkbox"/> headaches <input type="checkbox"/> bad breath <input type="checkbox"/> throat pain or sore throat <input type="checkbox"/> easy bruising <input type="checkbox"/> masses (lumps) in neck	<p>GENITOURINARY</p> <input type="checkbox"/> changes in urine color <input type="checkbox"/> dysuria (painful urination) <input type="checkbox"/> urinary frequency
<p>HEENT</p> <input type="checkbox"/> blurred vision <input type="checkbox"/> choking on liquids <input type="checkbox"/> choking on solids <input type="checkbox"/> diplopia (double vision) <input type="checkbox"/> dizziness <input type="checkbox"/> drooling <input type="checkbox"/> dysphagia (difficulty swallowing) <input type="checkbox"/> ear drainage <input type="checkbox"/> hoarseness or change in voice <input type="checkbox"/> mouth ulcers <input type="checkbox"/> otalgia (ear pain) <input type="checkbox"/> pharyngitis <input type="checkbox"/> tinnitus (ringing in ear) <input type="checkbox"/> vertigo <input type="checkbox"/> visual changes <input type="checkbox"/> hearing loss <input type="checkbox"/> lump in throat <input type="checkbox"/> nosebleeds <input type="checkbox"/> decrease sense of smell or taste <input type="checkbox"/> nasal or facial pain <input type="checkbox"/> pressure around nose	<p>RESPIRATORY</p> <input type="checkbox"/> apnea during sleep <input type="checkbox"/> shortness of breath <input type="checkbox"/> snoring <input type="checkbox"/> wheezing <input type="checkbox"/> non-productive cough <input type="checkbox"/> productive cough <input type="checkbox"/> coughing up blood	<p>METABOLIC/ENDOCRINE</p> <input type="checkbox"/> cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> increased thirst
	<p>CARDIOVASCULAR</p> <input type="checkbox"/> chest pain <input type="checkbox"/> heart murmur <input type="checkbox"/> palpitations <input type="checkbox"/> mitral valve prolapse	<p>NEUROLOGICAL</p> <input type="checkbox"/> difficulty falling asleep <input type="checkbox"/> difficulty staying asleep <input type="checkbox"/> excessive daytime sleepiness <input type="checkbox"/> non-restorative sleep <input type="checkbox"/> numbness in extremities <input type="checkbox"/> syncope (fainting) <input type="checkbox"/> tingling <input type="checkbox"/> tremor <input type="checkbox"/> weakness
	<p>GASTROINTESTINAL</p> <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn or indigestion <input type="checkbox"/> vomiting	<p>PSYCHIATRIC</p> <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> hallucinations
		<p>OTHER</p> <p>_____</p> <p>_____</p>

NAME _____

PAST HEALTH HISTORY: Check conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> alcoholism <input type="checkbox"/> anemia <input type="checkbox"/> arthritis <input type="checkbox"/> asthma <input type="checkbox"/> birth disorder <input type="checkbox"/> bleeding disorders <input type="checkbox"/> bronchitis <input type="checkbox"/> cancer, type _____ <input type="checkbox"/> chronic infection <input type="checkbox"/> congestive heart failure <input type="checkbox"/> COPD <input type="checkbox"/> coronary artery disease <input type="checkbox"/> CVA (stroke) <input type="checkbox"/> depression <input type="checkbox"/> diabetes <input type="checkbox"/> emphysema	<input type="checkbox"/> ENT Syndromes <input type="checkbox"/> GERD <input type="checkbox"/> glaucoma <input type="checkbox"/> Grave's disease <input type="checkbox"/> headaches <input type="checkbox"/> heart disease <input type="checkbox"/> hepatitis <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol <input type="checkbox"/> hyperthyroidism <input type="checkbox"/> hypothyroidism <input type="checkbox"/> HIV positive <input type="checkbox"/> kidney disease <input type="checkbox"/> liver disease <input type="checkbox"/> lupus <input type="checkbox"/> migraine headache <input type="checkbox"/> mononucleosis	<input type="checkbox"/> multinodular goiter <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> mumps <input type="checkbox"/> myocardial infarction (heart attack) <input type="checkbox"/> otosclerosis <input type="checkbox"/> prostate problems <input type="checkbox"/> psychiatric care <input type="checkbox"/> seizure disorder <input type="checkbox"/> sleep apnea <input type="checkbox"/> stomach ulcer <input type="checkbox"/> tinnitus <input type="checkbox"/> tonsillitis <input type="checkbox"/> tuberculosis <input type="checkbox"/> vertigo <input type="checkbox"/> other _____ <input type="checkbox"/> other _____ <input type="checkbox"/> No medical conditions
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FAMILY HISTORY

Check the box if you have a family history of any of the following conditions.
If someone in your family has a condition, list familial relationship (father, mother, brother, etc.)

Allergies _____

Asthma _____

Autoimmune disease (arthritis, lupus, MS, etc.) _____

CAD (Coronary artery disease) _____

Cancer (list person and type) _____

Cleft lip/ palate _____

CVA (stroke) _____

Depression _____

Developmental delay _____

Diabetes _____

GERD (reflux) _____

Hearing disorder _____

Hematological disorder (anemia, bleeding disorders, etc.) _____

Hyperlipidemia (high cholesterol/triglycerides) _____

Hypertension _____

Migraines _____

Obesity _____

Chronic otitis media _____

Otosclerosis _____

Renal disease _____

Seizure disorder _____

Sickle cell disease _____

Sleep apnea _____

Thyroid disorder _____

Other _____

No family history of medical conditions

Have you recently been hospitalized for a medical problem? Yes No If **yes**, list the reason for admission and the date.

NAME _____

CURRENT MEDICATIONS:

Are you taking **ANY** kind of medication now? (Including prescription, over-the-counter or herbal medicine) Yes No
(If **yes**, please list below *include dosages*.)

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES:

Are you allergic to any medications? Yes No (If **yes**, please list below.)

Medication Name	Type of Reaction	Severity (mild to severe)

Are you allergic to anything in the environment such as pollens, dust, food, etc.? Yes No If **yes**, please indicate what you are allergic to. _____

SURGERIES

Have you ever had surgery? Yes No If **yes**, list any surgeries and when they were done.

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes No If **yes**, please list what sort of problems. _____

SOCIAL HISTORY:

What is or was your occupation? _____ Check here if you are retired

Ethnicity _____ Do you use caffeine? Yes No Type _____ Usual amount _____

Do you consume **alcohol**? Yes No If **yes**, please list: Type of Alcohol _____ Amount per day _____

Have you **ever** used **tobacco** in any form? Yes No Do you **currently** use **tobacco** in any form? Yes No

Are you exposed to second hand smoke? Yes No If you **have used** or **currently use** tobacco please complete the following: Type of Tobacco _____ Amount per day: _____ Ever tried to quit Yes No

Total number of years of use _____ Year Quit _____ Longest tobacco free _____ Relapse reason _____

I certify that that information provided is **true** and **accurate** to the best of my knowledge.

Parent/Guardian Signature _____