Lone Star ENT & Allergy
Eric Hensen, DO.
112 Medical Dr.
Palestine, TX 75801
(903) 729-0444 - phone
(903) 729-7765 - fax

Patient Information

Today's Date: ___________________________

Name: ____ Male / Female Adult / Child
First *Middle* *Last*

Date of Birth: ________________________ SSN: _________________________ Marital Status: _______________

Mailing Address: ________________________________City: ______________________State: _______Zip: _______

Phone: Home_________________________ Cell__________________________ Work__________________________

Employer: ___________________________________ Local Pharmacy: ____________________________________

Email Address: ________________________________ Driver's License Number: _______________________________

Primary Care Physician: _____________________________Referring Physician: _____________________________

Complete this section ONLY IF someone other than the patient is financially responsible

Responsible Party: _________________________________ Relationship to Patient: ____________________________

Date of Birth: ________________________ SSN: _________________________ Marital Status: _______________

Mailing Address: ________________________________City: ______________________State: _______Zip: _______

Phone: Home_________________________ Cell__________________________ Work__________________________

Employer: ___________________________________ Employer Phone Number: ____________________________

Email Address: ________________________________ Driver's License Number: _______________________________

Name of Spouse: _________________________________ Male / Female

Date of Birth: ________________________ SSN: _________________________

Mailing Address: ________________________________City: ______________________State: _______Zip: _______

Phone: Home_________________________ Cell__________________________ Work__________________________

Employer: ___________________________________ Employer Phone Number: ____________________________

Email Address: ________________________________ Driver's License Number: _______________________________

Emergency Contact: _________________________________ Relationship to Patient: ___________________________

Phone: Home_________________________ Cell__________________________ Work___________________________

******Please provide your insurance card(s) and driver's license or picture ID******

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Financial Agreement

Name: ____ Today's Date: ________________________

First *Middle* *Last*

- **Our office requires 24-hour notice for cancellation of ANY appointment. If appropriate notice is not given or you No Show you will be charged a $50 fee.**
- Our Office will file insurance for all reimbursable services, to both primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts.
- I authorize use of this form on all my insurance submissions and request payment of authorized Medicare benefits and/or private insurance benefits be made to Eric L. Hensen, D.O., P.A. for services rendered to me. I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bills.

____ ________________________________

Signature of Patient / Parent / Responsible Party ***Date***

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required. Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at time of the visit and, in many cases, covers only the office visit charge. Any procedures preformed will be considered surgery by your insurance company and deductibles and coinsurance may apply. For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for the services I receive.

____ ________________________________

Signature of Patient / Parent / Responsible Party ***Date***

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Medical Information Release Form

Due to 2003 HIPPA laws, the release of patient's medical information has been restricted.

On the form below, please list any family member, friend or others we may release information to if they were to call our office and ask questions about an appointment date, surgery date, or any other treatment questions.

Names	**Information Access Preferences** ***Clinical Information / Financial***
______________________________	All ______ Restricted ______ Financial Only ______
______________________________	All ______ Restricted ______ Financial Only ______
______________________________	All ______ Restricted ______ Financial Only ______
______________________________	All ______ Restricted ______ Financial Only ______
______________________________	All ______ Restricted ______ Financial Only ______

If you checked the Restricted line above, please specify which clinical information you DO NOT wish to share with the person(s) listed above.

Sexually Transmitted Diseases _____
Mental / Behavioral Health _____
Pregnancy _____
Other ______________________
Terminal Illness _____

Preferred Means of Contact: ____

May we leave a message on an answering machine or voicemail? **Y or N**

- **I understand that I can grant and/or restrict access to my private health information with Eric L. Hensen, D.O, P.A.**
- **Health information is used and disclosed to carry out treatment, payment or operations.**
- **I understand that Eric L. Hensen, D.O, P.A. reserves the right to deny this request dependent upon the circumstances**

____ ______________________________

Signature of Patient / Parent / Responsible Party ***Date***

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NEW PATIENT INTAKE AND HISTORY FORM

(PRINT PLEASE)

Today's Date: ___________________________

Name: ____ **Date of Birth:** ___________________________

Local Pharmacy: ____
(Name / City / Phone #)

Mail Order Pharmacy: ____
(Name / City / Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: ____

Timing/Onset: When did the symptoms first occur? ____
Duration: Frequency of symptoms? ____
Characterized as/Severity: Describe the severity of the symptoms/pain. ___________________________________
Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _______________
____
Modifying Factors: What makes the condition better and/or worse? ____
Other Physicians/Specialists seen: ____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

__ Allergies (environmental)	__ Head/Neck Cancer	__ Hearing Loss	__ Obesity
__ Allergies (seasonal)	__ COPD (lung disease)	__ Heart Disease	__ Seizures
__ Anemia	__ Coronary Artery Disease	__ Hepatitis	__ Sinusitis
__ Anxiety	__ Depression	__ High Blood Pressure	__ Sleep Apnea
__ Arthritis	__ Diabetes	__ HIV / AIDS	__ Stroke
__ Asthma	__ Gastric Reflux	__ Irritable Bowel Syndrome	__ Thyroid Disorder
__ Cancer	__ Glaucoma	__ Migraine	

__ Other: ____

ALLERGY HISTORY:

___ NKDA (No Known Drug Allergies)
If Allergy noted, please list medication and reaction:
____
____
____

MEDICATION HISTORY:

__ I am not currently taking any medications.
List any medications, vitamins, minerals and herbals that you are currently taking:

Name of Medication:	Dosage:	How Often:

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (including deceased family members)? Place an X under the family member with the condition and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Asthma	_______	_______	_______	_______	_______	_______
Cancer	_______	_______	_______	_______	_______	_______
COPD	_______	_______	_______	_______	_______	_______
Diabetes	_______	_______	_______	_______	_______	_______
Heart Disease	_______	_______	_______	_______	_______	_______
High Blood Pressure	_______	_______	_______	_______	_______	_______
Migraines	_______	_______	_______	_______	_______	_______
Obesity	_______	_______	_______	_______	_______	_______
Seizures	_______	_______	_______	_______	_______	_______
Sleep Apnea	_______	_______	_______	_______	_______	_______
Thyroid Problems	_______	_______	_______	_______	_______	_______

Other: ____

PAST SURGICAL HISTORY:

Place an X next to any surgery you've previously had, along with the year it was done.

_______ None

_______ Anesthetic Complications
_______ Adenoidectomy
_______ Back Surgery
_______ Breast Surgery – R / L
_______ Cataract Surgery – R / L
_______ Cholecystectomy
_______ Cosmetic Surgery
_______ Craniotomy
_______ Ear Tubes – R / L
_______ Ear Surgery - R / L
_______ Endartectomy
_______ Hypophysectomy (partial)
_______ Hypophysectomy (total)

_______ Hysterectomy (partial / total)
_______ Laryngectomy (partial)
_______ Laryngectomy (total)
_______ Reduction of Nasal Frac
_______ Mastoidectomy
_______Myringoplasty
_______ Myringotomy – R / L
_______ Nasal Sinusotomy
_______ Neck Surgery
_______ Ovary Removal - R / L
_______ Parathyroidectomy
_______ Reduction of Facial Frac
_______ Rhinoplasty

_______ Sinus Surgery
_______ Sleep Apnea Surgery
_______ Spinal Fusion (neck)
_______ Tonsillectomy
_______ Tracheostomy
_______ Tubal Ligation
_______ Tympanostomy

Other: ____

SOCIAL HISTORY:

Would you Accept a Blood Transfusion if needed? ___ Yes ___ No

Please describe your current/past tobacco use, along with how much:

___ Never a Smoker
___ Smoker-how much/how often ____
___ Former Smoker-how much did you previously smoke? How long ago did you quit? ___________________________

If you currently use tobacco or have in the past, please indicate what type (cigarettes, cigars, pipe, chew) and for how long: ____

Do you drink alcoholic beverages? ___ Yes ___ No
If yes, please indicate what type of beverage and how many times per week: ____________________________________

Have you ever used illicit drugs? ___ Yes ___ No
If yes, please indicate what type of drug and how often: ____

Describe your current sleep:

___ No Complaints ___ Daytime Drowsiness ___ Difficulty Falling Asleep
___ Early Waking ___ Napping ___ Using CPAP

Do you drink caffeinated beverages? ___ Yes ___ No
If yes, please indicate what type of beverage and how many times per week: ____________________________________

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: **Normal**
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Tiredness
- ☐ Weight Gain >20lbs
- ☐ Weight Gain >10lbs

Skin: **Normal**
- ☐ Acne
- ☐ Bruising
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Itching
- ☐ New Lesions
- ☐ Ulcer
- ☐ Rash
- ☐ Hives

HEENT: **Normal**
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Vertigo
- ☐ Runny Nose
- ☐ Sinusitis
- ☐ Seasonal Allergies
- ☐ Sneezing
- ☐ Nasal Congestion
- ☐ Nose Bleed
- ☐ Headache
- ☐ Glaucoma
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Choking Sensation
- ☐ Oral Ulcers

Neck: **Normal**
- ☐ Neck Mass
- ☐ Swollen Glands
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Swelling

Respiratory: **Normal**
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Bloody Sputum
- ☐ Chronic Cough
- ☐ Difficulty Breathing on Exertion
- ☐ Snoring
- ☐ Sputum Production
- ☐ Wakes up from Sleep Wheezing or Short of Breath

Cardiovascular: **Normal**
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Attack
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Heart Stent
- ☐ Hypertension

Musculoskeletal: **Normal**
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Fibromyalgia
- ☐ Upper Extremity Weakness

Psychiatric: **Normal**
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Memory Loss
- ☐ Change in Sleep Pattern
- ☐ Insomnia
- ☐ Trouble Falling Asleep

Gastrointestinal: **Normal**
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Mass
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion

Neurological: **Normal**
- ☐ Dizziness
- ☐ Fainting
- ☐ Facial Paralysis
- ☐ Seizures
- ☐ Migraines
- ☐ Stroke

Endocrine: **Normal**
- ☐ Cold Intolerance
- ☐ Thyroid Problems
- ☐ Hair Changes

Hematology: **Normal**
- ☐ Anemia
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Blood Clots

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Lone Star ENT, Allergy and Aesthetic Patients

This notice is to ensure you, our patient, that proper precautions are taken by our staff to protect you from any illness that is easily transferrable from person to person while in our office. Examples of common illnesses, especially during the fall and winter months are seasonal flu, common cold viruses, and Noroviruses (stomach bug). As you well know, COVID-19 has been included as well.

In order to keep our patients safe, these precautions are taken by our office staff:

-Treatment rooms are cleaned and disinfected with hospital grade cleaner between each patient.

-Disinfecting of equipment used to examine patients is done by using alcohol-based cleaner or by sterilization.

-Proper hand hygiene is done before patients are seen **AND** after patient care.

If, for any reason, you feel uncomfortable with precautions taken by our office, please reschedule your appointment for a later date.

If you agree to being treated in our office at this time, please sign your name at the bottom of this form with today's date. Thank you for letting us participate in your care.

Lone Star ENT, Allergy and Aesthetics Care Team

Patient Signature: ___________________________________ Date: ____________________