Nicole Bryan, MD

Patient Information

Patient Information (Please use full legal name)			
Last	First		Middle
Address			Home Phone
City	State	Zip	Cell Phone
At what number would you prefer to be contacted? ___ Cell ___ Home ___ Work	May we leave a message?		
Date of Birth	Age	Sex	Marital Status
Social Security #	Driver's License	E-mail Address	
Employer Name			Work Phone
Employer Address			
Emergency Contact Name	Phone Number	Relationship	
Ethnicity and Race (Please answer both sections, it is a federal requirement that we request and record this information)			
Ethnicity: please indicate which applies to you ___ Hispanic or Latino ___ Not Hispanic or Latino	Race: Please pick the category with which you most closely identify ___ American Indian or Alaskan Native ___ Native Hawaiian ___ Asian or Pacific Islander ___ White or Caucasian ___ Black or African American Other ______________________		
What is your Language of Preference? Please note: The appointment will be conducted in English unless previous arrangements have been made.			
How did you find our practice? If a physician referred you please provide their Name and Phone Number			
Primary Care Physician	Phone Number		
Preferred Pharmacy: If you do not know phone number please provide city and cross streets:	Phone Number		
Are you covered by Medicare? Yes No Initial ______			

Guarantor Information (Person responsible for bill - Please use full legal name)			
Relationship to Patient: Self _________ Spouse _________ Parent _________ Other _________			
Information same as above: Yes _________ No _________ if no, please complete below			
Last	First		Middle
Address			Home Phone
City	State	Zip	Cell Phone
Date of Birth	Age	Sex	Marital Status
Social Security #	Driver's License		
Employer Name			Work Phone
Employer Address			

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Financial Policy

Please read and initial each of the following and sign to acknowledge receipt of this information.

_____ I hereby authorize payments directly to Nicole Bryan, MD, PLLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered on behalf of myself or my dependents, whether or not paid by insurance.

_____ I authorize Nicole Bryan, MD, PLLC and/or any provider or supplier of services in this office to release any information required to secure payment of benefits. I authorize the use of the signature below on all insurance submissions. This assignment will remain in effect until revoked by me in writing.

_____ I have read and understand the office **Financial Policy** as detailed below

- It is the patient's responsibility to provide current and accurate insurance and billing information and to inform this office if this information changes at any time.
- All co-pays, deductibles, co-insurance or costs for non-covered services are due at the time of service. Most insurance contracts require payment to the practice at <u>every</u> appointment even if it is a follow up for the same condition.
- As medical providers, our relationship is with you, the patient, and not your insurance company. It is your responsibility to know and understand the level of services allowed by your insurance company.
- While every effort is made to verify insurance coverage prior to the provision of services, the provided information is only an estimate from the insurance company and the actual amount owed may vary. We have no control over what services your insurance will or will not cover or the level of coverage it may provide. We will be happy to assist you by providing any information you may need in discussion with your insurance company.
- Additional in-office procedures which may include, but are not limited to, minor procedures, hearing testing or endoscopy (ie use of a "scope") may involve additional charges beyond those for an office visit. We will be happy to verify coverage prior to the procedure but this may require scheduling the procedure for a different visit to allow time to obtain this information.
- We will send a statement to the billing address you provide informing you of any balances you may owe. Payment in full is due on receipt of this statement. If you have any questions regarding this statement, please contact our office at 972-492-4006.

____   ________________________

Signature of Patient or Responsible Party   Date

____   _________________________

Printed Name   Date of Birth

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Medical History

Name:	Date of Birth:	Date:

What is your main complaint today?

Allergies to Medications

Current Medications
(include prescription and over the counter medications, include dose and how often you take the medication)

Medical Problems for which you are currently treated or have received treatment in the last 24 months:
Check all that apply

☐ Allergies ☐ Head Injury ☐ Thyroid ☐ Stomach Problems ☐ High Blood Pressure ☐ Kidney Problems ☐ Other	☐ Diabetes ☐ Eczema ☐ Lung Problems ☐ Blood Clots ☐ Latex Allergy ☐ Liver Problems	☐ Asthma ☐ Skin Disease ☐ Heart Problems ☐ Stroke ☐ Cancer	☐ Reactive Airway Disease ☐ Hearing Loss ☐ Tinnitus ☐ Snoring

Past Surgeries or Procedures

History of Complications from Anesthesia (please explain)

Tobacco Use	**Alcohol Use**
☐ Current Smoker: __________ packs per day for _______ years ☐ Other tobacco use: _________________________________ ☐ Quit: ______________ years ago ☐ Never used tobacco	☐ Current use: ______________ drinks per week ☐ Quit: _____________ years ago ☐ No Alcohol Use

Family History: check all that apply

☐ Cancer ☐ Diabetes ☐ Seizures	☐ Excessive Bleeding ☐ High Blood Pressure ☐ Mental Illness	☐ Problems with anesthesia ☐ Heart attack or Stroke at Young Age ☐ Other

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Allergy History

Name:	**Date of Birth:**	**Date**:
What are your primary allergy symptoms?		
List medications you are currently taking for allergy or sinus treatment: include prescription and over the counter medications		
List medications, other than those listed above, you have tried in the past for allergy or sinus treatment: Include prescription and over the counter medications		
Number of sinus infections requiring treatment you have had in the last 12 months, include dates of treatment and names of antibiotics that were used. This information is often required for insurance approval for further testing if needed. Please provide as much information as possible.		
Have you ever had a CT scan or other imaging of the sinuses? If so, when was it performed?		
Have you ever been on allergy shots (allergy desensitization)? If so, when and for how long were you were under treatment?		
When do you have the most allergy or sinus problems? ☐ Summer ☐ Fall ☐ Winter ☐ Spring ☐ All Year Round		
List number and type of pets in your home		
Does anyone in your home smoke?		