CENTRAL TENNESSEE
EAR, NOSE & THROAT

Patient Information

Last Name:________________ First Name:________________ MI:________

Date of Birth:________________ Sex: M____ F____ Other____ Social Security: ________________

Street Address:________________ Apt#________

City:________________ State:________ Zip:________

Home#________ Cell#________ Email:________________

Employer:________________ Work#________

Primary Care Doctor________________ Referring Doctor________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Other

Race: ☐ White/Caucasian ☐ Am. Indian/Alaska Native ☐ Asian ☐ Black/African ☐ Hawaiian/Other Islander ☐ Other race

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Preferred Language**: ☐ English ☐ Spanish ☐ Other________

Person Responsible for Patient Account

☐ **Check if Self**

Last Name:________________ First Name:________________ DOB:________

Address:________________ City________ State:________ Zip:________

SSN:________________ Phone#________________ Relationship to Patient:________

Employer:________________ Work#________

In Case of Emergency Contact

Name:________________ Phone:________ Relationship to patient:________

Insurance Information

1. Insurance:________________ Policy#________________ Group#________

Policy Holder Name:________________ DOB:________ Relationship to Patient:________

Address:________________ City/State/Zip:________________ Phone#________

2. Insurance:________________ Policy#________________ Group#________

Policy Holder Name:________________ DOB:________ Relationship to Patient:________

Address:________________ City/State/Zip:________________ Phone#________

Pharmacy Information

Pharmacy:________________ Location:________________ Phone:________

Signature of Patient/Representative:________________ **Date:**________

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called “the providers”) may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _______ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: ____

Signature of Patient: ____ Date: __________

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: ______________________________

Relationship: ____ Telephone: ______________

Address: ____

Signature of the above: ________________________________ Date: __________ Time: __________

Signature of Witness: ____ Date: __________

AdvancedHEALTH