

**Southern California Ear, Nose, & Throat**

**Nina S. Yoshpe, M.D. Ayal Willner, M.D. Kathy Yu-Syken, M.D. Christy Beranek, PA-C**

**PLEASE PRINT CLEARLY**

**Minor Patient Information**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Gender: M F  
Primary Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Parent/Emergency Contact Information**

Mother's First Name: \_\_\_\_\_ Last: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address If Different: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Father's First Name: \_\_\_\_\_ Last: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address If Different: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Emergency Contact other than Parent: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

Primary Insurance

Secondary Insurance

Subscriber/Relation: \_\_\_\_\_ Subscriber/Relation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Medical Group: \_\_\_\_\_ Medical Group: \_\_\_\_\_  
Insured's ID# \_\_\_\_\_ Insured's ID# \_\_\_\_\_  
Group of Policy# \_\_\_\_\_ Group of Policy# \_\_\_\_\_

Circle One: HMO PPO POS EPO MEDICAL SELF PAY

Have you met your deductible yet? YES NO Do you have a co pay? YES NO Amount \$ \_\_\_\_\_

**Assignment and Release**

1. I hereby assign my insurance benefits to be paid directly to Dr.Yoshpe/Dr.Willner/Dr.Yu-Syken. It is understood that in case the patient's insurance company does not make payment, this obligation shall be binding personally upon the patient.

2. Dr.Yoshpe/Dr.Willner/Dr.Yu-Syken is granted permission to release to the insurance carrier or their representative any necessary insurance information. Permission is given to correspond with the referring physician regarding medical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CROSS STREETS: \_\_\_\_\_

GUARANTORS EMAIL ADDRESS: \_\_\_\_\_

# OTOLARYNGOLOGY CLINICAL HISTORY

## PATIENT IDENTIFICATION

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

## CHIEF COMPLAINT

Reason for Visit: \_\_\_\_\_ Duration: \_\_\_\_\_

**MEDICATIONS – LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING WITH DOSAGE AND FREQUENCY (INCLUDE "OVER THE COUNTER MEDICATIONS")**

DRUG NAME (GENERIC/BRAND)	DOSAGE	FREQUENCY	STATUS
			<input type="checkbox"/> CHRONIC <input type="checkbox"/> ACUTE <input type="checkbox"/> DC'D
			<input type="checkbox"/> CHRONIC <input type="checkbox"/> ACUTE <input type="checkbox"/> DC'D
			<input type="checkbox"/> CHRONIC <input type="checkbox"/> ACUTE <input type="checkbox"/> DC'D
			<input type="checkbox"/> CHRONIC <input type="checkbox"/> ACUTE <input type="checkbox"/> DC'D
			<input type="checkbox"/> CHRONIC <input type="checkbox"/> ACUTE <input type="checkbox"/> DC'D

## ALLERGIES – LIST YOUR ALLERGIES INCLUDING ANY MEDICATIONS THAT CAUSED AN ALLERGIC REACTION

LIST ALL ALLERGIES	ALLERGIC REACTION

## PAST MEDICAL HISTORY – PLEASE PROVIDE A COMPLETE HISTORY INCLUDING ALL ILLNESSES, INJURIES, HOSPITALIZATIONS AND OPERATIONS

LIST ALL ILLNESSES, INJURIES & OPERATIONS	DATE	HOSPITAL	TREATMENT	PHYSICIAN

## FAMILY HISTORY – PLEASE LIST ALL BLOOD RELATIVES WITH THEIR CURRENT HEALTH STATUS, ILLNESSES, AGE IF LIVING, AGE AT DEATH & CAUSES OF DEATH

LIST BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	STATE OF HEALTH	ILLNESSES
MOTHER					
FATHER					
SISTER					
BROTHER					

## SOCIAL HISTORY- PLEASE CHECK THE APPROPRIATE BOXES AND FILL IN ACCURATE AMOUNTS OF STANDARD PORTIONS (TO BE FILLED OUT BY ADULTS)

<b>Mental Work</b> <input type="checkbox"/> Heavy <input type="checkbox"/> Omit <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No. Hours Per Day: _____	<b>Physical Work</b> <input type="checkbox"/> Heavy <input type="checkbox"/> Omit <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No Hours Per Day: _____	<b>Exercise</b> <input type="checkbox"/> Heavy Type: _____ <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No. Hours Per Week: _____	<b>Alcohol</b> <input type="checkbox"/> Beer /Week: _____ <input type="checkbox"/> Liquor/Week: _____ <input type="checkbox"/> Wine /Week: _____ No. Of Years: ___ <input type="checkbox"/> None	<b>Smoking</b> <input type="checkbox"/> Current <input type="checkbox"/> Previous No. Of Packs / Day: _____ No. of Years: ___ Quit Yr: ___ Other: _____ <input type="checkbox"/> None
<b>Caffeine</b> <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Other: _____ Cups Per Day: _____ No. Of Years: _____ <input type="checkbox"/> None	<b>Aspirin</b> No. Per Day: _____ No. Of Years: _____ Other: _____ <input type="checkbox"/> None	<b>Nutritional Information</b> <input type="checkbox"/> Low Sodium Diet <input type="checkbox"/> Diabetic Diet <input type="checkbox"/> Low Fat Diet <input type="checkbox"/> Vegetarian Diet <input type="checkbox"/> Low Cholesterol Diet <input type="checkbox"/> Other: _____	<b>Miscellaneous Drugs</b> <input type="checkbox"/> Vitamins <input type="checkbox"/> Pain Pills <input type="checkbox"/> Marijuana <input type="checkbox"/> Laxatives <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Cocaine <input type="checkbox"/> Antacids <input type="checkbox"/> Nutrasweet <input type="checkbox"/> Amphetamines <input type="checkbox"/> Diet Pills <input type="checkbox"/> Saccharin <input type="checkbox"/> Other: _____	

# OTOLARYNGOLOGY CLINICAL HISTORY (2)

**VITAL SIGNS:** HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP(↑) / (L) / (→) / PULSE \_\_\_\_\_ TEMP. \_\_\_\_\_

**SOCIAL HISTORY- PLEASE CHECK THE APPROPRIATE BOXES AND FILL IN ACCURATE AMOUNTS OF STANDARD PORTIONS**

<b>Mental Work</b> <input type="checkbox"/> Heavy <input type="checkbox"/> Omit <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No. Hours Per Day: _____	<b>Physical Work</b> <input type="checkbox"/> Heavy <input type="checkbox"/> Omit <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No Hours Per Day: _____	<b>Exercise</b> <input type="checkbox"/> Heavy Type: _____ <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None No. Hours Per Week: _____	<b>Alcohol</b> <input type="checkbox"/> Beer /Week: _____ <input type="checkbox"/> Liquor/Week: _____ <input type="checkbox"/> Wine /Week: _____ No. Of Years: _____ <input type="checkbox"/> None	<b>Smoking</b> <input type="checkbox"/> Current <input type="checkbox"/> Previous No. Of Packs / Day: _____ No. of Years: _____ Quit Yr: _____ Other: _____ <input type="checkbox"/> None
<b>Caffeine</b> <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Other: _____ Cups Per Day: _____ No. Of Years: _____ <input type="checkbox"/> None	<b>Aspirin</b> No. Per Day: _____ No. Of Years: _____ Other: _____ <input type="checkbox"/> None	<b>Nutritional Information</b> <input type="checkbox"/> Low Sodium Diet <input type="checkbox"/> Diabetic Diet <input type="checkbox"/> Low Fat Diet <input type="checkbox"/> Vegetarian Diet <input type="checkbox"/> Low Cholesterol Diet <input type="checkbox"/> Other: _____	<b>Miscellaneous Drugs</b> <input type="checkbox"/> Vitamins <input type="checkbox"/> Pain Pills <input type="checkbox"/> Marijuana <input type="checkbox"/> Laxatives <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Cocaine <input type="checkbox"/> Antacids <input type="checkbox"/> Nutrasweet <input type="checkbox"/> Amphetamines <input type="checkbox"/> Diet Pills <input type="checkbox"/> Saccharin <input type="checkbox"/> Other _____	

**REVIEW OF SYMPTOMS – CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY**

<b>GENERAL:</b>	<input type="checkbox"/> WEAKNESS	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> FEVER	<input type="checkbox"/> CHILLS	<input type="checkbox"/> NIGHT SWEATS	<input type="checkbox"/> FAINTING
<b>SKIN:</b>	<input type="checkbox"/> COLOR CHANGES	<input type="checkbox"/> RASHES	<input type="checkbox"/> ITCHING	<input type="checkbox"/> SORES		
<b>HEAD:</b>	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> HEAD INJURIES	<input type="checkbox"/> HEAD LESIONS	<input type="checkbox"/> HEAD/FACIAL LESIONS		
<b>EYES:</b>	<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> EYE REDNESS	<input type="checkbox"/> ITCHY EYES	<input type="checkbox"/> BURNING EYES		
	<input type="checkbox"/> EYE SWELLING	<input type="checkbox"/> EYE PAIN	<input type="checkbox"/> DRY EYES	<input type="checkbox"/> TEARING		
<b>EARS:</b>	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> RINGING	<input type="checkbox"/> EAR DISCHARGE	<input type="checkbox"/> EARACHE	<input type="checkbox"/> ITCHY EARS	<input type="checkbox"/> LOSS OF BALANCE
	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> ROOM SPINS	<input type="checkbox"/> EAR BLOCKAGE/OBSTRUCTION	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> EAR LESIONS/SORES/DEFORMITY	
<b>NOSE:</b>	<input type="checkbox"/> LOSS OF SMELL	<input type="checkbox"/> NOSE BLEEDS	<input type="checkbox"/> NASAL PAIN	<input type="checkbox"/> NASAL DISCHARGE	<input type="checkbox"/> NASAL OBSTRUCTION	
	<input type="checkbox"/> NASAL CONGESTION	<input type="checkbox"/> SNORING	<input type="checkbox"/> POST NASAL DRIP	<input type="checkbox"/> DEVIATED SEPTUM	<input type="checkbox"/> RUNNY NOSE	
	<input type="checkbox"/> SINUS CONGESTION	<input type="checkbox"/> NASAL SORES/LESIONS				
<b>MOUTH:</b>	<input type="checkbox"/> BLEEDING GUMS	<input type="checkbox"/> ORAL SORES	<input type="checkbox"/> DENTAL PROBLEMS	<input type="checkbox"/> MOUTH/JAW PAIN	<input type="checkbox"/> BAD BREATH	<input type="checkbox"/>
<b>LOSS OF TASTE:</b>	<input type="checkbox"/> DRY MOUTH	<input type="checkbox"/> ORAL ULCERS	<input type="checkbox"/> ORAL BLISTERS	<input type="checkbox"/> BAD TASTE		
<b>THROAT:</b>	<input type="checkbox"/> SORE THROAT	<input type="checkbox"/> BAD TONSILS/TONSILLITIS	<input type="checkbox"/> HOARSENESS			
	<input type="checkbox"/> HARD TO SWALLOW	<input type="checkbox"/> RECURRENT INFECTIONS	<input type="checkbox"/> ORAL WHITE SPOTS			
<b>NECK:</b>	<input type="checkbox"/> NECK ENLARGEMENT	<input type="checkbox"/> NECK STIFFNESS	<input type="checkbox"/> NECK SORENESS/PAIN	<input type="checkbox"/> NECK LUMPS	<input type="checkbox"/> NECK MASSES	
<b>LUNGS:</b>	<input type="checkbox"/> COUGH	<input type="checkbox"/> PHLEGM	<input type="checkbox"/> COUGHED BLOOD	<input type="checkbox"/> SHORTNESS OF BREATH		
	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> PAIN IN LUNGS	<input type="checkbox"/> CHEST CONGESTION	<input type="checkbox"/> INHALANT EXPOSURE		
<b>HEART:</b>	<input type="checkbox"/> MURMUR	<input type="checkbox"/> PALPITATIONS	<input type="checkbox"/> RAPID HEARTBEAT	<input type="checkbox"/> SWOLLEN EXTREMITIES	<input type="checkbox"/> COLD EXTREMITIES	
	<input type="checkbox"/> CHEST TIGHTNESS/PRESSURE	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> VARICOSE VEINS	<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> BLUE EXTREMITIES	
<b>GASTROINTESTINAL:</b>	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VOMITING	<input type="checkbox"/> ABDOMINAL BLOATEDNESS		
	<input type="checkbox"/> BELCHING	<input type="checkbox"/> HEARTBURN	<input type="checkbox"/> INDEGESTION			
<b>NEUROLOGICAL:</b>	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> VERTIGO	<input type="checkbox"/> LOSS OF FACIAL EXPRESSION	<input type="checkbox"/> PARALYSIS	<input type="checkbox"/> SLURRED	
	SPEECH	<input type="checkbox"/> TINGLING/BURNING/NUMBNESS	<input type="checkbox"/> DISORIENTATION			
<b>PSYCHIATRIC:</b>	<input type="checkbox"/> HYPERVENTILATION	<input type="checkbox"/> ALCOHOL ABUSE	<input type="checkbox"/> DRUG USAGE	<input type="checkbox"/> DRUG ABUSE/ADICTION		
<b>ENDOCRINE:</b>	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> WEIGHT GAIN	<input type="checkbox"/> HOARSENESS/VOICE CHANGES			
	<input type="checkbox"/> HYPOGLYCEMIA/LOW BLOOD SUGAR	<input type="checkbox"/> DIABETES/HIGH BLOOD SUGAR				

# PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

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To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.