Southern California Ear, Nose, & Throat

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PLEASE PRINT CLEARLY

Patient Information

First Name:______________ Middle Initial:________ Last:________________

Address:____________________ City:______________ State:______ Zip:________

SSN:______-_____-______ Age:_____ Date of Birth:___/___/____

Home:(_____) _____-______ Cell:(_____) _____-______ Ethnicity:______________ Gender: M F

Employer: ______________________Work: (____) ____-______ Ext: ________

Address:____________________ City:______________ State:______ Zip:________

Primary Physician:______________ Address: ______________________

City: ______________ State:______ Zip:________ Phone:(_____)_____- ______

Referring Physician:______________ Address:______________________

City:______________ State:______ Zip:________ Phone:(_____) _____-______

Spouse/Partner/Emergency Contact Information

Spouse/Partner First Name:______________ Last:______________ Date of Birth:___/___/____

SSN: ______-_____-______ Cell: (_____) _____-______ Work: (_____) _____-_____ Gender: M F

Address If Different:______________ City:______________ State:______ Zip:________

Employer: ______________ Address: ______________________

Emergency Contact: ______________ Relation to Pt: ________ 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: ______________

PATIENTS 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
			☐ CHRONIC ☐ ACUTE ☐ DC'D
			☐ CHRONIC ☐ ACUTE ☐ DC'D
			☐ CHRONIC ☐ ACUTE ☐ DC'D
			☐ CHRONIC ☐ ACUTE ☐ DC'D
			☐ CHRONIC ☐ ACUTE ☐ 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)

Mental Work	Physical Work	Exercise	Alcohol	Smoking
☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No. Hours Per Day: ______	☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No Hours Per Day: ______	☐ Heavy Type: ______ ☐ Moderate ______ ☐ Light ☐ None No. Hours Per Week: ______	☐ Beer /Week: ______ ☐ Liquor/Week: ______ ☐ Wine /Week: ______ No. Of Years: ____ ☐None	☐ Current ☐ Previous No. Of Packs / Day: No. of Years: ___ Quit Yr:___ Other: ______ ☐ None

Caffeine	Aspirin	Nutritional Information	Miscellaneous Drugs
☐ Coffee ☐ Tea ☐ Cola ☐ Other: ______ Cups Per Day: ______ No. Of Years: ______ ☐ None	No. Per Day: ______ No. Of Years: ______ Other: ______ ☐ None	☐ Low Sodium Diet ☐ Diabetic Diet ☐ Low Fat Diet ☐ Vegetarian Diet ☐ Low Cholesterol Diet ☐ Other: ______	☐ Vitamins ☐ Pain Pills ☐ Marijuana ☐ Laxatives ☐ Sleeping Pills ☐ Cocaine ☐ Antacids ☐ Nutrasweet ☐ Amphetamines ☐ Diet Pills ☐ Saccharin ☐ 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

Mental Work	Physical Work	Exercise	Alcohol	Smoking
☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No. Hours Per Day: ______	☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No Hours Per Day: ______	☐ Heavy Type: ______ ☐ Moderate ______ ☐ Light ☐ None No. Hours Per Week: ______	☐ Beer /Week: ______ ☐ Liquor/Week: ______ ☐ Wine /Week: ______ No. Of Years: ____ ☐None	☐ Current ☐ Previous No. Of Packs / Day: ______ No. of Years: ___ Quit Yr: ___ Other: ______ ☐ None

Caffeine	Aspirin	Nutritional Information	Miscellaneous Drugs
☐ Coffee ☐ Tea ☐ Cola ☐ Other: ______ Cups Per Day: ______ No. Of Years: ______ ☐ None	No. Per Day: ______ No. Of Years: ______ Other: ______ ☐ None	☐ Low Sodium Diet ☐ Diabetic Diet ☐ Low Fat Diet ☐ Vegetarian Diet ☐ Low Cholesterol Diet ☐ Other: ______	☐ Vitamins ☐ Pain Pills ☐ Marijuana ☐ Laxatives ☐ Sleeping Pills ☐ Cocaine ☐ Antacids ☐ Nutrasweet ☐ Amphetamines ☐ Diet Pills ☐ Saccharin ☐ Other______

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

GENERAL: ☐ Weakness ☐ Fatigue ☐ Fever ☐ Chills ☐ Night Sweats ☐ Fainting

SKIN: ☐ Color Changes ☐ Rashes ☐ Itching ☐ Sores

HEAD: ☐ Headaches ☐ Head Injuries ☐ Head Lesions ☐ Head/Facial Lesions

EYES: ☐ Blurred Vision ☐ Eye Redness ☐ Itchy Eyes ☐ Burning Eyes ☐ Eye Swelling ☐ Eye Pain ☐ Dry Eyes ☐ Tearing

EARS: ☐ Hearing Loss ☐ Ringing ☐ Ear Discharge ☐ Earache ☐ Itchy Ears ☐ Loss of Balance ☐ Dizziness ☐ Room Spins ☐ Ear Blockage/Obstruction ☐ Ear Infections ☐ Ear Lesions/Sores/Deformity

NOSE: ☐ Loss of Smell ☐ Nose Bleeds ☐ Nasal Pain ☐ Nasal Discharge ☐ Nasal Obstruction ☐ Nasal Congestion ☐ Snoring ☐ Post Nasal Drip ☐ Deviated Septum ☐ Runny Nose ☐ Sinus Congestion ☐ Nasal Sores/Lesions

MOUTH: ☐ Bleeding Gums ☐ OralSores ☐ Dental Problems ☐ Mouth/Jaw Pain ☐ Bad Breath ☐ Loss of Taste ☐ Dry Mouth ☐ Oral Ulcers ☐ Oral Blisters ☐ Bad Taste

THROAT: ☐ Sore Throat ☐ Bad Tonsils/Tonsillitis ☐ Hoarseness ☐ Hard To Swallow ☐ Recurrent Infections ☐ Oral White Spots

NECK: ☐Neck Enlargement ☐ Neck Stiffness ☐ Neck Soreness/Pain ☐ Neck Lumps ☐ Neck Masses

LUNGS: ☐ Cough ☐ Phlegm ☐ Coughed Blood ☐ Shortness of Breath ☐ Wheezing ☐ Pain in Lungs ☐ Chest Congestion ☐ Inhalant Exposure

HEART: ☐ Murmur ☐ Palpitations ☐ Rapid Heartbeat ☐ Swollen Extremities ☐ Cold Extremities ☐ Chest Tightness/Pressure ☐ Chest Pain ☐ Varicose Veins ☐ Blood Clots ☐ Blue Extremities

GASTROINTESTINAL: ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Abdominal Bloatedness ☐ Belching ☐ Heartburn ☐ Indegestion

NEUROLOGICAL: ☐ Seizures ☐ Vertigo ☐ Loss of Facial Expression ☐ Paralysis ☐Slurred Speech ☐ Tingling/Burning/Numbness ☐ Disorentation

PSYCHIATRIC: ☐ Hyperventilation ☐ Alcohol Abuse ☐ Drug Usage ☐ Drug Abuse/Adiction

ENDOCRINE: ☐ Weight Loss ☐ Weight Gain ☐ Hoarseness/Voice Changes ☐ Hypoglycemia/Low Blood Sugar ☐ Diabetes/High Blood Sugar

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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: __________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

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.