

Southern California Ear, Nose, & Throat

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PLEASE PRINT CLEARLY

Patient Information

First Name: _____ Middle Initial: _____ Last: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: ____/____/____ Home: (____) ____-____ Cell: (____) ____-____
Ethnicity: _____ Gender: M/ F Social Security # _____
Employer Name: _____ Occupation: _____ Work: (____) ____-____ Ext: _____
Employer 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: ____/____/____
Cell: (____) ____-____ Work: (____) ____-____ Gender: M / F
Address If Different: _____ City: _____ State: _____ Zip: _____
Employer Name: _____ Employer Address: _____
Emergency Contact: _____ Relation to Patient: _____ 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 #: _____ Phone #: (____) ____-____	Group of Policy #: _____ Phone #: (____) ____-____
Subscriber DOB: ____/____/____	Subscriber DOB: ____/____/____
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.Varma. 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.Varma 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 ☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No. Hours Per Day: _____	Physical Work ☐ Heavy ☐ Omit ☐ Moderate ☐ Light ☐ None No Hours Per Day: _____	Exercise ☐ Heavy Type: _____ ☐ Moderate ☐ Light ☐ None No. Hours Per Week: _____	Alcohol ☐ Beer /Week: _____ ☐ Liquor/Week: _____ ☐ Wine /Week: _____ No. Of Years: _____ ☐ None	Smoking ☐ Current ☐ Previous No. Of Packs / Day: _____ No. of Years: ____ Quit Yr: ____ Other: _____ ☐ None
Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ Other: _____ Cups Per Day: _____ No. Of Years: _____ ☐ None	Aspirin No. Per Day: _____ No. Of Years: _____ Other: _____ ☐ None	Nutritional Information ☐ Low Sodium Diet ☐ Diabetic Diet ☐ Low Fat Diet ☐ Vegetarian Diet ☐ Low Cholesterol Diet ☐ Other: _____	Miscellaneous Drugs ☐ Vitamins ☐ Pain Pills ☐ Marijuana ☐ Laxatives ☐ Sleeping Pills ☐ Cocaine ☐ Antacids ☐ NutraSweet ☐ Amphetamines ☐ Diet Pills ☐ Saccharin ☐ Other: _____	

OTOLARYNGOLOGY CLINICAL HISTORY (2)

VITAL SIGNS : HEIGHT _____ WEIGHT _____ BP(↑) _____ / _____ (↓) _____ / _____ (→) _____ PULSE _____ TEMP. _____

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

1 in 3 Americans have undiagnosed sleep disorder.
 40% of all Americans report difficulty either falling asleep or staying asleep.
 Sleep problems add an estimated \$15.9 billion to national healthcare costs.
 Those who have untreated sleep apnea are 4 times more likely to suffer from a stroke.
 It is estimated 90% of the population of obstructive sleep apnea has not been diagnosed.
 Nearly half of people with obstruction sleep apnea are also diagnosed with hypertension.
 People with sleep apnea are three times more likely to be involved in motor vehicle accidents.

Sleep Disorder Questionnaire

Name: _____ Height: _____ Weight: _____ DOB: _____

CHECK THE FOLLOWING THAT APPLY:

- | | | |
|--|---|--|
| ☐ High Blood Pressure | ☐ Congestive Heart Failure | ☐ Chronic Fatigue |
| ☐ Coronary Artery Disease | ☐ Insomnia | |
| ☐ History of Stroke | ☐ Mood Disorders | |

Points

- | | | |
|---|--|----------|
| Have you been told that you stop breathing while asleep? | ☐ Yes ☐ No | 8 |
| Have you ever fallen asleep or nodded off while driving? | ☐ Yes ☐ No | 6 |
| Do you awaken suddenly with shortness of breath, gasping or with your heart racing? | ☐ Yes ☐ No | 6 |
| Do you feel excessively tired during the day? | ☐ Yes ☐ No | 4 |
| Has anyone ever told you that you snore while you are sleeping? | ☐ Yes ☐ No | 4 |
| Have you had weight gain and found it difficult to lose? | ☐ Yes ☐ No | 2 |
| Have you take medication for or been diagnosed with high blood pressure? | ☐ Yes ☐ No | 2 |
| Do you kick or jerk your legs while sleeping? | ☐ Yes ☐ No | 3 |
| Do you feel burning, tingling, or crawling sensations in your legs while you are awake? | ☐ Yes ☐ No | 3 |
| Do you wake up with headaches during the night or in the morning? | ☐ Yes ☐ No | 3 |
| Do you have trouble falling asleep? | ☐ Yes ☐ No | 4 |
| Do you have trouble staying asleep once you fall asleep? | ☐ Yes ☐ No | 4 |

Score & Risk Factor: _____

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Sino-Nasal Outcome Test-22 Questionnaire v4

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate you answering the following question to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems, as they have been over the past two weeks. Thank you for your participation.

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how 'bad' it is by circling the number that corresponds with how you feel using this scale →

	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain/pressure	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Waking up at night	0	1	2	3	4	5
13. Lack of a good night's sleep	0	1	2	3	4	5
14. Waking up tired	0	1	2	3	4	5
15. Fatigue during the day	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5
21. Sense of taste/smell	0	1	2	3	4	5
22. Blockage/congestion of nose	0	1	2	3	4	5

TOTAL: _____

For Medical Use Only

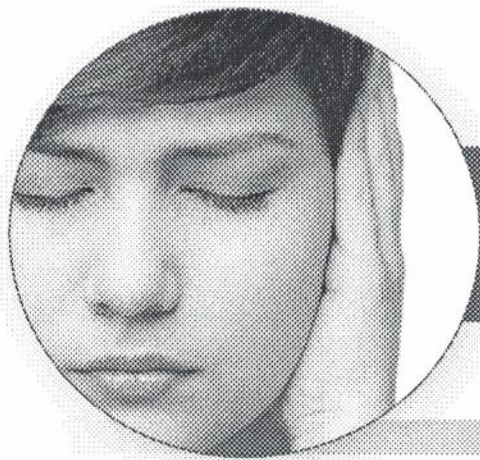
GRAND TOTAL: _____

Patient No.: d.o.b.: Date:

M F

Diagnosis: Aims of Treatment:

Today's treatment: L-M score:



Eustachian Tube Dysfunction

Patient Questionnaire (ETDQ-7)¹

Name: _____ Date: _____

Next to each question, circle the number that best describes how you feel.

During the past 1 month, how much of a problem was each of the following?	No Problem		Moderate Problem		Severe Problem	
1. Pressure in the ears?	1	2	3	4	5	6 7
2. Pain in the ears?	1	2	3	4	5	6 7
3. A feeling that your ears are clogged or "under water"?	1	2	3	4	5	6 7
4. Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6 7
5. Crackling or popping sounds in the ears?	1	2	3	4	5	6 7
6. Ringing in the ears?	1	2	3	4	5	6 7
7. A feeling that your hearing is muffled?	1	2	3	4	5	6 7

Do you get these symptoms in one ear only or both ears?

☐ Left ear only ☐ Right ear only ☐ Both ears

Total Score _____ $\div 7 =$ **Mean item score** _____

1. ETDQ-7 Copyright 2012 by McCoul ED, Anand VK and Christos PJ. Weill Cornell Medical College, New York, New York.

Caution: Federal (U.S.) law restricts the sale, distribution or use of the ACCLARENT AERA™ by or on the order of a physician who is trained in the use of Acclarent technology. Eustachian tube balloon dilation has associated risks, including tissue and mucosal trauma, infection, or possible carotid artery injury. Prior to use, it is important to read the Instructions for Use and to understand the contraindications, warnings, and precautions associated with these devices.

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 healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare 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 healthcare information and information about treatment, payment or healthcare 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 healthcare 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 you 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 your HIPPA 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 natural 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 (HIPPA) 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.

Southern California Ear, Nose and Throat

Nina S. Yoshpe MD, Ayal Willner MD, Namrata Varma DO, Christy Beranek PA-C

Insurance Verification / Cancellation Policy

I understand it is my responsibility to confirm that Southern California Ear, Nose and Throat is an in-network provider with my insurance policy _____ (initial here)

I understand that if there are any changes within my insurance plan or provider, I am responsible to prove this information to Southern California Ear, Nose and Throat. I also understand, that if I have a HMO, this requires obtaining a new authorization from my new medical group via my primary care physician _____ (initial here)

I understand pending my benefits and my insurance plan, I may be responsible for payment at the time of my visit, Co-pays are due at the time of my visit _____ (initial here)

I understand that I am responsible for my deductible and any co-insurance depending on my plan. I will be billed for any remaining balance after my insurance company has processed my claims _____ (initial here)

I understand that appointments are pre-arranged and it is my responsibility to keep my appointment or cancel my appointment with a minimum of 24-hour notice. Failure to cancel will result in a \$24 cancellation fee. _____ (initial here)

Name of patient: _____

Signature of patient or parent / guardian: _____

Date: _____