Southern California Ear, Nose, & Throat

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Minor Patient Information

PLEASE PRINT CLEARLY

First Name: _____ Middle Initial: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____Date of Birth: ___/___/_____ Home: (_____) _____-_____ Cell: (_____) _____-_____

Ethnicity: _____ Gender: M / F Social Security #_____

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: ____/____/____

Cell: (_____) _____-_____ Work: (_____) _____-_____ Social Security #_____

Address If Different: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Employer Address: _____

Father's First Name: _____ Last: _____ Date of Birth: ___/____/_____

Cell: (_____) _____-_____ Work: (_____) _____-_____ Social Security # _____

Address If Different: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ 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 #: _____ 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: _____

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
			❒ 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 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

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: _____ _____ _____ _____ _____

GRAND TOTAL: _____

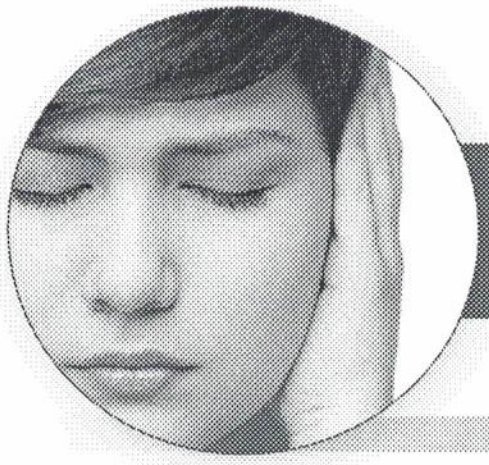
For Medical Use Only

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 _____ **÷ 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.

ACCLARENT AERA®
Eustachian Tube Balloon Dilation System

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 Questionaire

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+

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: _____