Patient Registration Form

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____ (First) _____ (MI) _____

Date of Birth (Mo/Day/Year) _____

Address _____

City, State _____ Zip _____

Telephone Home _____ Mobile _____

Work _____

I authorize ENT Group of LA to leave personal health information on voicemail: ☐ Mobile ☐ Home

Email Address _____

Sex ☐ Female ☐ Male ☐ Transgender: _____

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Other

Primary language (if not English) _____

Primary Care Doctor _____ Who referred you? _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship to patient _____

Emergency Contact Phone Number _____ Email _____

Preferred Pharmacy _____

Responsible Party Information

Responsible Party ☐ Self ☐ Another Patient ☐ Guarantor

Check here if information is same as patient ☐

Responsible Party Name (Last) _____ (First) _____ (MI) ____

Date of Birth (Mo/Day/Year) _____

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with excellent care and service. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

1) Contact the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified (typically two to three days after the test), I will call the office for my test results. Do not assume that "no news is good news" as the doctors aim to communicate all results, positive or negative.

2) Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

3) Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Name of Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____

Name: _____ Date: _____

Reason for Visit: _____ Duration of Problem: _____

Medications (with strength and dosage)	
1	6
2	7
3	8
4	9
5	10

Medical Problems – past & present (i.e. migraine, high blood pressure, diabetes, asthma, etc.)	

Allergies Drug or Food	Reaction	Drug or Food	Reaction

Family History Relative	Alive or Deceased	Medical Problem (i.e. cancer, genetic disease, etc.)
Mother		
Father		
Other		

Previous Surgeries or Hospitalizations (please list with dates)	

Do you drink alcoholic beverages? Yes No Amount _____

Do you use tobacco? Yes No Amount _____

Are you pregnant or nursing? Yes No N/A

Current Symptoms (check all that apply)

- ☐ Weight loss of 20 lbs. or more (last 6 mos.)
- ☐ Fever or Chills
- ☐ Weakness
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Frequent nosebleeds
- ☐ Difficulty swallowing
- ☐ Change in voice
- ☐ Throat pain
- ☐ Difficulty sleeping
- ☐ Loss of vision
- ☐ Sensitivity to bright light
- ☐ Headache
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Excessive sweating or Feeling very cold
- ☐ Frequent Urination
- ☐ Itching
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Heartburn
- ☐ Recent vomiting
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Hepatitis
- ☐ Swollen joints
- ☐ Muscle aches or cramps
- ☐ Eczema
- ☐ Blistering of skin
- ☐ History of keloids
- ☐ Photosensitivity
- ☐ Rash
- ☐ Depression
- ☐ Anxiety

Other medical problems, please list:_____

_____

Has anyone in your family had a problem with anesthesia? Yes No

If yes, please describe: _____

Do you, or any blood relatives, have a bleeding problem with surgery or cuts? Yes No

Do you take aspirin, ibuprofen, herbal medications, or similar blood thinners? Yes No

Is there any other information you think we should know?

_____

_____

Advance Notice of Non-Covered Services

Physician Notice

I am being advised by this letter that my insurance will only pay for services that it determines to be "medically necessary" and that are covered benefits. If my insurance company determines that a particular service, although it would be otherwise covered, is not medically necessary or a covered benefit, they will deny payment for that service. If something is not covered, I understand that I will be billed for payment on those services.

Beneficiary Agreement

I have been notified by my physician that he/she believes that the insurance carrier is likely to reimburse for medically necessary services; however, if the insurance company denies payment, I agree to be personally and fully responsible for the payment.

Waiver Form

I acknowledge that if my insurance does not show me eligible for coverage with the doctor I am seeing today, I will be responsible for paying for my medical services "in full".

Name of Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I am voluntarily seeking medical care and treatment. I give permission to the medical staff of ENT Group of Los Angeles ("ENTGLA") to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

I consent to the use or disclosure of my protected health information by ENTGLA for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ENTGLA may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ENTGLA is not required to agree to the restrictions that I may request. However, if ENTGLA agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing, at any time, except to the extent that ENTGLA has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ENTGLA Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices will be provided to me on request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations by ENTGLA. The Notice of Privacy Practices for ENTGLA practice is provided in a blue binder located in the waiting area. This Notice of Privacy Practices also describes my rights and ENTGLA's duties with respect to my protected health information.

ENTGLA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by fax, or asking for one at the time of my next appointment.

Name of Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____