Ear, Nose and Throat Associates of San Diego

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Full Time Student: ☐ Yes ☐ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other _____

Referring Physician's Name: _____ Phone No: _____

Primary Care Physician's Name: _____ Phone No.: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply. Any unpaid balance is due within 30 days of services.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Practices:

I acknowledge that a copy of the current notice or Privacy Practices will be posted in the reception area and I will get offered a copy of any amended notice of Privacy Practices at each appointment. I acknowledge that a copy of the Current Notice of Privacy Practices has been offered to me.

Patient/Guardian Signature: _____ **Date:** _____

ENT Associates of San Diego
Ear, Nose and Throat Associates of San Diego
A Medical Corporation

Otolaryngology for Adults and Children
Head and Neck Surgery

JOHN TAYLOR, M.D.*
PATRICK G. McCALLION, M.D.F.A.C.S.*
JEREMIAH J. MOLES, M.D.*
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Patient Contact Information Restriction

The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your Protected Health Information.

I wish to be contacted in the following manner (**please check all that apply**):

- ☐ **Home Phone** ( ) _____ - _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with callback number only
- ☐ **Cell Phone** ( ) _____ - _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with callback number only
- ☐ **Work Phone** ( ) _____ - _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with callback number only

☐ I hereby **consent** to the release of my medical information to the people listed below. This authorization will be in effect until I change it.

☐ I hereby **decline** the release of my medical information to anybody. This authorization will be in effect until I change it.

Name	**Relationship**

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Print Patient's Name **Date of Birth**

ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** This information will be entered into your electronic medical record. You are welcome to a copy of the report if you wish.

Full Name _____ **Male** ☐ **Female** ☐ **Could you be pregnant?** ☐ **Yes** ☐ **No**

E-mail address _____

Pharmacy Preference (include location) _____ **Preferred Language** _____

What is or was your occupation? _____ ☐ **Check here if you are retired.**

Primary Care Physician _____ **Referring Physician** _____

Preferred Reminder Method for Test Notifications:

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Other Phone ☐ Opt Out
☐ Home Fax ☐ Work Fax ☐ Mail ☐ Patient Portal

Optional - Please check the correct answers

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander ☐ Some Other Race ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Have you been diagnosed with hepatitis? ☐ **Yes** ☐ **No** **If yes, which type?** ☐ **A** ☐ **B** ☐ **C**

CURRENT MEDICATIONS: Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) ☐ **Yes** ☐ **No** **If YES, please list below.**

Name of Medication (Prescribed, Over-the-Counter, or Herbal)	Name of Medication (Prescribed, Over-the-Counter, or Herbal)

MEDICATION ALLERGIES: Are you ALLERGIC to ANY MEDICATIONS? ☐ **Yes** ☐ **No**
If YES, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to anything in the environment such as pollens, dust, food, etc.? ☐ **Yes** ☐ **No**
If YES, please indicate what you are allergic to. _____

Have you ever had an allergy test? ☐ **Yes** ☐ **No** **If YES check: Skin**____ **or Blood** _____

- **SURGERIES AND HOSPITALIZATIONS:**
  Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **Yes** ☐ **No**
  If YES, please list what sort of problems. _____
- Have you ever had ear, nose or throat surgery? ☐ **Yes** ☐ **No**
  If YES, list any surgeries and when they were done. _____
- Have you ever had any major surgeries before? ☐ **Yes** ☐ **No**
  If YES, list the type and year. _____
- Have you been hospitalized for a medical problem before? ☐ **Yes** ☐ **No**
  If YES, list hospitalizations, the reason for admission and the date. _____

Patient Health History

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Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Skin Cancer	○	Stomach Ulcer	○
Throat Cancer	○		
Prostate Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
		Hemophilia	○
Heart Attack	○		
High Blood Pressure	○	HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use:
Mark your tobacco use.

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Do you use drugs recreationally? Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

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12. Do you now have or have you recently had any of the following?

	Yes
Fever	○
Sleeping problems	○
Unintentional weight loss	○
Unintentional weight gain	○
Blurred vision	○
Itchy eyes	○
Loss of vision	○
Painful eye	○
Dizziness	○
Ear drainage	○
Hearing loss	○
Ear pain	○
Ringing in the ears	○
Nasal congestion	○
Frequent nosebleeds	○
Post-nasal drainage	○
Belching sour material into throat	○
Hoarseness or other voice changes	○
Mouth ulcers	○
Partials or dentures	○
Blacking out or fainting	○
Chest pain	○
Heart murmur	○
Irregular heartbeats	○
Leg cramps	○
Swelling of ankles	○
Frequent non-productive cough	○
Frequent productive cough	○
Shortness of breath	○
Snoring (excessive)	○
Wheezing	○
Abdominal pain	○
Diarrhea	○
Heartburn	○
Nausea	○
Trouble swallowing	○
Painful swallowing	○
Vomiting	○
Painful joints	○
Stiffness in joints	○
Swelling of joints	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes
Change in sense of smell	○
Change in sense of taste	○
Headache	○
Severe face pain	○
Seizures	○
Tremor	○
Appetite is increased	○
Fatigue	○
Cold feeling	○
Bleed excessively after injury	○
Bruise easily	○
Masses (lumps) in armpit	○
Masses (lumps) in neck	○
Masses (lumps) in groin	○
Hives	○
Sneezing	○

Patient Name _____

We are required to ask our patients the following questions.
We appreciate your cooperation.

ALL PATIENTS 6 MONTHS OF AGE AND OLDER

Have you had a FLU shot in the past 12 months? ☐ Yes ☐ No
If yes, in what month and year? _____

ALL PATIENTS AGES 50 THROUGH 75

<u>Colorectal Cancer Screening</u>

Have you had a colonoscopy in the past 9 years? ☐ Yes ☐ No
If yes, in what year? _____

Have you had a fecal occult blood test in the past 12 months? ☐ Yes ☐ No
If yes, in what month and year? _____

Have you had a flexible sigmoidoscopy in the past 4 years? ☐ Yes ☐ No
If yes, in what year? _____

Do you have a history of colon cancer? ☐ Yes ☐ No

ALL PATIENTS 65 YEARS OF AGE AND OLDER

Have you ever had a PNEUMONIA shot? ☐ Yes ☐ No
If yes, in what year? _____

FEMALE PATIENTS ONLY

(If age 40 through 69) Have you had a mammogram within the last 2 years? ☐ Yes ☐ No
If yes, in what year? _____

(If age 40 through 69) Have you had a mastectomy? ☐ Yes ☐ No

(If age 21 through 64) Have you had a Pap test within the last 2 years? ☐ Yes ☐ No
If yes, in what year? _____