NORTH COUNTY EAR NOSE & THROAT,
HEAD AND NECK SURGERY
Pediatric and Adult
3909 Waring Rd, Ste A
Oceanside, CA 92056

ADULT PATIENT REGISTRATION Today's Date _____

Patient Name _____ Date of Birth ___/___/___ Age _____

Phone Numbers: H _____ W _____ Cell _____

Street Address _____ City_____ Zip_____

Email Address _____ Patient Social Security # _____

Emergency contact name and phone number: _____

Preferred Language _____ Interpreter name and phone number_____

Can we leave voice mail messages with health information at the above number(s) and relay health information

(such as test results) to whomever answers at the above number(s)? Yes____ No____

Referring Provider _____ **Primary Care Provider** _____

Insurance information

Member's Name _____ Social Security #: _____ Employer _____

Primary insurance _____ Policy # _____

Secondary insurance _____ Policy # _____

Insurance preferred lab _____ Insurance preferred radiology facility_____

Release/Assignment/Acknowledgement

I hereby authorize North County Ear, Nose and Throat, Head and Neck Surgery, Inc. to release pertinent information to other health care providers involved in my dependent's care and/or insurance companies holding policies on my dependent.

I authorize my insurance company to directly remit payment to North County Ear, Nose and Throat, Head and Neck Surgery, Inc. for medical and surgical services provided.

I understand that I am ultimately responsible for all charges incurred. It is my responsibility to know my insurance and make sure that if I am using an HMO my dependent has an authorization from their primary care doctor and/or insurance company to see this doctor.

I understand that by not providing the office with all information requested and/or copies of my insurance card(s) at the time of service, this could delay the processing of my claim and I could be personally responsible for payment of these services.

Notice to consumers: I understand that medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbca.gov

Privacy Notice Record-I acknowledge that I have received a copy of the Notice of Privacy Practices. My signature below indicates my acceptance/understanding of the above statements.

Signature of patient or legal guardian_____ Date _____

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ADULT PATIENT MEDICATION FORM

Today's Date _____

1. Patient Name: _____ **Date of Birth** ___/___/___

2. Pharmacy information: Please list the name, phone number and address of your preferred **pharmacy**:

Pharmacy name: _____ Phone Number: _____

Street Address: _____ City_____ ZIP Code _____

3. Medications: Please list **all** medications you are currently taking (including herbal supplements, vitamins, aspirin, nasal sprays, other "over-the-counter" medications, etc.) and **dosage:**

Check here if none ☐

Medication	Dosage	Medication	Dosage

4. Allergies: Please list any allergies and the type of reaction (include medications, latex, xray dye, food, environmental):

Check here if none ☐

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PATIENT NAME _____ **DATE OF BIRTH** _____

Financial Policy

Your insurance policy is a contract between you and your insurance company. Therefore, you are responsible for the cost for services you receive from North County Ear, Nose & Throat, Head and Neck Surgery, Inc. If our office has a contract with your insurance company, we will bill your insurance for you. It is your responsibility to know whether prior authorization or a second opinion is required by your insurance company prior to any office visit, surgery, or hospitalization. This requirement may affect your benefits and amounts by your insurance. Please inform this office if such authorization is required before services are rendered.

It is also your responsibility to notify us of any change in your insurance type, primary physician, primary medical group, or if other changes have occurred that could affect your insurance coverage for services about to be provided. If we are not informed prior to rendering services, you may be responsible for the cost of the services.

We accept assignment for all Medicare patients. Co-payments and deductibles are due and payable at each visit. We regret that a charge of $4 must be added when a bill is mailed for any co-pays due and a $10 charge added to each overdue bill.

Disability Forms

Because disability and other related forms have become more prevalent, extensive and therefore more time-consuming to fill out, there is now a minimum $20 charge for completing them. This is not covered by insurance and is therefore the patient's responsibility.

Returned Checks

There is a $20 charge for returned checks.

Missed Appointments and Canceled Surgery

Your appointment time is reserved for you. If you are unable to keep the office appointment, we request that you notify us at least 6 working hours beforehand. For surgeries, a 72 hour notification is needed. This allows us to schedule another patient in your timeslot. If we are notified later than that, there is a $50 charge for missed physician appointments and surgery, and a $40 charge for missed audiology appointments.

Signature of patient or legal guardian_____ Date _____

FOR PHYSICIAN USE ONLY:

The physician has reviewed the above information.

Physician stamp or signature:_____Date_____

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ADULT PATIENT MEDICAL HISTORY FORM

1. Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ Weight_____

Referring Provider _____ **Primary Care Provider** _____

2. Chief complaint: What is the reason for your visit?

_____

3. Past medical history: Medical problems for which you have **previously** been treated or are **currently** being treated. If yes, please circle specific condition and provide details if needed. Please add any others not listed.

YES	NO		YES	NO	
☐	☐	Acid reflux _____	☐	☐	Heart disease (heart attack, A-fib, murmur, other) _____
☐	☐	AIDS/HIV _____	☐	☐	Hepatitis (type A, B, C) _____
☐	☐	Anesthesia problems _____	☐	☐	Hypertension (high blood pressure) _____
☐	☐	Arthritis _____	☐	☐	Immune problems_____
☐	☐	Bleeding problems (eg nose, surgical, gums, menstrual cycle) _____	☐	☐	Kidney disease _____
☐	☐	Blood clots _____	☐	☐	Lung Disease (asthma, pneumonia, tuberculosis, other) _____
☐	☐	Cancer/what type? _____	☐	☐	Migraines _____
☐	☐	Dementia (eg Alzheimer's) _____	☐	☐	Rheumatic fever_____
☐	☐	Depression, bipolar, anxiety, other _____	☐	☐	Sleep apnea _____
☐	☐	Diabetes _____	☐	☐	Stroke _____
☐	☐	Environmental allergies _____	☐	☐	Thyroid disease_____
☐	☐	Glaucoma _____	Other		
☐	☐	Head or neck radiation _____	_____		
☐	☐	Hearing problems_____	_____		

5. Surgical history: Please list **any surgeries** and the **dates** they were performed:

_____

_____

_____

Patient Name _____ **Date of Birth** _____

6. Social history:

YES NO

☐ ☐ Have you ever or do you now use tobacco?

If yes, how many cigarettes/cigars/pipes per day:_____

For how many years: _____

Quit date: _____

Do you want to quit? _____

YES NO

☐ ☐ Do you drink alcohol?

If yes, average number of drinks per week:_____

☐ ☐ Do you use marijuana? _____

☐ ☐ Other recent illegal drug use? _____

Current occupation:_____ **Prior occupations**:_____

7. Family history: Please list any medical problems that run in the FAMILY (e.g. bleeding problems, anesthesia problems, chronic illnesses, heart disease, cancer, high blood pressure, stroke, etc.):_____

_____

8. Other questions:

YES NO

☐ ☐ Currently pregnant _____

☐ ☐ Breastfeeding _____

Date of last menstrual period _____

☐ ☐ Do we have your approval to obtain an HIV test if indicated?

9. Review of systems: If yes, please circle. Add additional information if needed.

YES NO

☐ ☐ **Constitutional:** Fevers, unintentional weight loss, recent cold or flu_____

☐ ☐ **Eyes:** Decreased vision, double vision _____

☐ ☐ **CV:** Chest pain, racing heart _____

☐ ☐ **Pulm**: Shortness of breath, wheezing, coughing spells _____

☐ ☐ **GI:** Nausea, vomiting, diarrhea, abdominal pain _____

☐ ☐ **GU:** Pain when urinating, blood in urine _____

☐ ☐ **MSK:** Sore or painful joints, sore or painful muscles, leg swelling _____

☐ ☐ **Derm/Heme:** Rashes, eczema, excessive bleeding or easy bruising _____

☐ ☐ **Neuro:** Dizziness, fainting, headaches, weakness in arms or legs _____

☐ ☐ **Psych:** Depressed, anxious _____

10. Signature of patient or legal guardian _____ **Date** _____