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

PEDIATRIC/TEEN PATIENT REGISTRATION Today's Date _____

Patient Name _____ Date of Birth ___/____/____ Age ___(yrs) ___ (mos)

Parent/Guardian 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

Primary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth: _____ Employer _____

Secondary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth:_____ Employer _____

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 parent or legal guardian_____ Date _____

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

PEDIATRIC/TEEN 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 your child is 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 ☐

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

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 parent or legal guardian_____ Date _____

FOR PHYSICIAN USE ONLY:

The physician has reviewed the above information.

Physician stamp or signature:_____Date_____

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

PEDIATRIC/TEEN 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 child's visit?

_____

3. Birth history:

YES	NO	
☐	☐	Problems with pregnancy or delivery _____
☐	☐	Hospitalizations in the intensive care unit _____
☐	☐	Intubations _____
☐	☐	Intravenous (IV) antibiotics _____

4. Past medical history: Medical problems for which your child has previously been treated or is 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 _____	☐	☐	Environmental Allergies _____
☐	☐	AIDS/HIV _____	☐	☐	Head or neck radiation _____
☐	☐	Anesthesia problems _____	☐	☐	Hearing problems_____
☐	☐	Birth Defects _____	☐	☐	Heart murmur _____
☐	☐	Bleeding problems (eg nose, surgical, gums, menstrual cycle) _____	☐	☐	Immune problems_____
☐	☐	Cancer/what type? _____	☐	☐	Lung Disease (asthma, pneumonia, tuberculosis, other) _____
☐	☐	Developmental delay (eg speech)_____	☐	☐	Rheumatic fever_____
☐	☐	Depression, bipolar, anxiety, other _____	☐	☐	Thyroid disease_____
☐	☐	Diabetes _____	Other _____		

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

_____

_____

Patient Name _____ Date of Birth _____

6. Social history: Who does the child live with? _____

YES	NO		For teens: YES	NO	
☐	☐	Secondhand smoke exposure _____			
☐	☐	Currently in school or daycare _____	☐	☐	Current tobacco use _____
☐	☐	Afterschool care _____	☐	☐	Past tobacco use _____
☐	☐	Activities (sports, music) _____	☐	☐	Other drug use (eg. marijuana, other) _____
☐	☐	Immunizations up to date _____	☐	☐	Alcohol use _____

7. Family history: Please list any medical problems that may run in the FAMILY (e.g. bleeding problems, anesthesia problems, chronic illnesses, congenital abnormalities etc.): _____

_____

8. Other questions:

YES	NO		
☐	☐	Currently pregnant_____	Date of last menstrual period _____
☐	☐	Breastfeeding _____	
☐	☐	Do we have your approval to obtain an HIV test on your child if indicated?	

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

YES	NO	
☐	☐	**Constitutional:** Fevers, unintentional weight loss, snoring/sleep apnea _____
☐	☐	**Eyes:** Decreased vision, double vision _____
☐	☐	**CV:** Chest pain, racing heart _____
☐	☐	**Pulm**: Shortness of breath, wheezing _____
☐	☐	**GI:** Nausea, vomiting, diarrhea, abdominal pain _____
☐	☐	**GU:** Pain when urinating, blood in urine _____
☐	☐	**MSK:** Sore or painful joints, sore or painful muscles _____
☐	☐	**Derm/Heme:** Rashes, eczema, excessive bleeding or easy bruising _____
☐	☐	**Neuro:** Dizziness, fainting, headaches _____
☐	☐	**Psych:** Depressed, anxious _____

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