The Allergy Center at Sacramento Ear, Nose & Throat

# Patient Information

**Please print neatly and fill out every item as accurately as possible.** Ask a staff member if you require assistance in filling out this form.

**Doctor:** _____ **Acct:** _____ **Date:** _____

**Name:** _____
First Middle Last

**Date of Birth:** _____ ☐ Male ☐ Female **SSN** _____-____-_____
mm/dd/yyyy

**Address:** _____
Street City State Zip

**Home Phone:** (_____) _____ **Cell Phone:** (_____) _____

**Employer:** _____ **Work Phone:** (_____) _____

**Email:** _____ **Preferred Language:** _____

**Emergency Contact:** _____ _____ (_____) _____
Name Relationship Phone

**Race:** _____ **Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Other: _____

| Primary Insurance Information | Secondary Insurance Information |
|---|---|
| Insurance Name: | Insurance Name: |
| Insurance ID: | Insurance ID: |
| Group or Policy Number: | Group or Policy Number: |
| Policy Holder's Name: | Policy Holder's Name: |
| Policy Holder's Relationship to Patient: | Policy Holder's Relationship to Patient: |
| Policy Holder's SSN: Date of Birth: | Policy Holder's SSN: Date of Birth: |

**Primary Care Physician (Family Doctor):** _____

**Referring Physician:** _____

**Medicare/Medi-Cal Lifetime Signature on File:**

I request that payment of authorized Medicare/Medi-Cal benefits be made on my behalf to Sacramento Ear, Nose & Throat Surgical Medical Group, Inc., for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.

**Private Insurance Authorization for Assignment of Benefits/Information Release:**

I, the undersigned, authorize payment of medical benefits to Sacramento Ear Nose & Throat Surgical Medical Group, Inc., for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims of benefits.

**As part of your visit you may have additional services performed to enable a thorough assessment. Additional services during your visit will result in additional charges for those procedures. By signing below you confirm that you have read and understand this statement.**

_____ _____
Signature Date

**ADULT**

The Allergy Center at Sacramento Ear, Nose & Throat

# Medication | Allergy Form

What is the reason for your visit today? _____

List all current medications, including any over the counter (OTC) medications or supplements

☐ Not taking any medications

| Name of Medication and Dosage |
|---|
| |
| |
| |
| |
| |
| |
| |

List any drug allergies or medicines you cannot take ☐ No known drug allergies

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Pharmacy:** Name: _____ Address: _____

Phone #: _____ Fax#: _____

## Non-Medication Allergies

Have you ever had allergy testing? ☐ No ☐ Yes When: _____

Have you ever taken allergy shots? ☐ No ☐ Yes

Are you currently taking shots? ☐ No ☐ Yes

Are you allergic to any of the following? ☐ Latex ☐ Tape ☐ Foods _____

☐ Other _____

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# Past Health History

**Please indicate any diseases that you have had or been diagnosed with by a doctor.**

☐ **No Major Illnesses**

**Childhood Diseases**
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Other_____

**Cancer**
- ☐ Breast
- ☐ Leukemia
- ☐ Lung
- ☐ Other_____

**Congenital (Birth) Problems**
- ☐ Congenital Malformation
- ☐ Down Syndrome
- ☐ Prematurity
- ☐ Other_____

**Ears, Nose & Throat**
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Sleep Apnea
- ☐ TMJ Dysfunction
- ☐ Other_____

**Heart**
- ☐ Angina (chest pain)
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Other_____

**Lungs**
- ☐ Asthma
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ Other_____

**Skin**
- ☐ Rosacea
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other_____

**Bones/Joints**
- ☐ Arthritis: ☐ Osteo ☐ Rheumatoid
- ☐ Osteoporosis
- ☐ Other_____

**Digestive**
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Hepatitis - Type: A B C
- ☐ Irritable Bowel Syndrome
- ☐ Reflux
- ☐ Gallbladder Disease (Stones)
- ☐ Other_____

**Brain/Nervous System**
- ☐ Alzheimer's/Dementia
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Headache
- ☐ Other_____

**Mental/Emotional Health**
- ☐ Anxiety Disorder
- ☐ Bi-Polar
- ☐ Depression
- ☐ Other_____

**Glands/Hormones**
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Grave's Disease
- ☐ Thyroid Disease: ☐ Hyper ☐ Hypo

**Allergies/Immune System**
- ☐ AIDS/HIV
- ☐ Autoimmune Disorder
- ☐ Lupus
- ☐ Other_____

**History of Any Other Condition:**
- ☐ _____
- _____
- _____

**Female Patients:** **Are you pregnant?**
- ☐ Yes
- ☐ No
- ☐ Possibly/Not Sure

## Surgeries

**Have you ever had problems with anesthesia (being put to sleep for surgery)?** _____
(Please Describe)

**Please indicate any ENT surgeries you have had:** ☐ No Surgery

**Ears** ☐ Ear Tubes ☐ Other
**Nose** ☐ Rhinoplasty ☐ Septoplasty ☐ Sinus ☐ Other_____
**Mouth/Neck** ☐ Tonsil/Adenoid ☐ Thyroid - Total or Partial? ☐ Other_____

**Please list any other major surgeries:**
_____
_____
_____

**Have you ever had a serious injury?** ☐ No ☐ Yes _____
(Please Describe)

**Patient Preferred Imaging Center** _____

**Patient Preferred Lab** _____

☐ I understand it is my responsibility to know which imaging centers and laboratories are in network and covered by my insurance plan.

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# Social History

**Current Occupation:** _____ ☐ Disabled ☐ Retired ☐ Student

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating

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**Current Tobacco Use?** ☐ Never ☐ Yes: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew

**When did you start?** Age: _____ or Year: _____ Average Use Per Day: _____

☐ Quit

**When did you stop?** Age: _____ or Year: _____

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**Alcohol Use?** ☐ No ☐ Yes

**Types and average number per week?** Beer: _____ Wine: _____ Wine Coolers: _____
Mixed Drinks or Liquor: _____

**Have you ever been dependent on or addicted to any drugs?** ☐ No ☐ Yes _____
(Please Describe)
☐ Prefer to discuss with doctor

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# Notice of Acknowledgement Advance Directive

**Patient Name:** _____

**DOB:** _____

**An advance directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. Advance Directives are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care. The instrument may be revoked and a notation of the date and time must be made to the patient's medical record.**

## Do you have an Advance Directive?

**A. Directive to Physicians (Living Will)** Yes _____ No _____

**B. Durable Power of Attorney for Health Care** Yes _____ No _____

**Is it up to date?** Yes _____ No _____

**Where is a copy located?** _____

**Principal Agent:** _____

**Address:** _____

**Phone #:** _____

_____ _____

Signature of Patient or Representative Date

The Allergy Center at Sacramento Ear, Nose & Throat

# Privacy Consent and Authorization for Use | Disclosure Form

Sacramento Ear, Nose & Throat Surgical Medical Group, Inc., and S.E.N.T. Hearing Aid Center (Collectively "SacENT") recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own record containing their Protected Health Information ("PHI"). I understand I have the right to review SacENT's Notice of Privacy Practices prior to signing this form. SacENT reserves the right to revise its Notice of Privacy Practices at any time.

## Consent:

With this consent, SacENT may use and disclose any PHI about myself (or my child) to carry out treatment, payment (including collection of payments), and healthcare operations. Please refer to SacENT's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, this office may mail to my home or other designated location or leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations, such as appointment reminders, insurance items, payment items, and any other information regarding my (or my child's) healthcare as long as they are marked "Personal and Confidential". With my consent, SacENT may e-mail any information regarding my (or my child's) health care, treatment, payment and appointments to me.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public at https://openpaymentsdata.cms.gov.

## Notice to Patients:

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

I understand I have the right to request that SacENT restricts how it uses and discloses my health care information to carry out treatment and payment. SacENT is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing below, I acknowledge receiving the above information.

That SacENT may also disclose, in it professional judgement, my health care information to such persons directly involved with my health care or payment thereof:

## Authorized Persons:

| First Name | Last Name | Phone Number | Relationship |
|---|---|---|---|
| | | | |
| First Name | Last Name | Phone Number | Relationship |
| | | | |

## I have read and received a copy of the Notification Privacy Practices.

Patient's Name _____ Patient Date of Birth _____

Signature of Patient/Parent or Legal Guardian _____ Date _____

The Allergy Center at Sacramento Ear, Nose & Throat

# Healthcare Communications Authorization Form

Please indicate below your preferred communication method(s) for _____
Patient Name

## Text Message

I, _____, authorize Sacramento Ear, Nose & Throat and The Allergy Center to send appointment reminders and other healthcare communications electronically via text message to my mobile phone. I understand this service is free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message communication for the following mobile phone number:

_____ Mobile #

_____ Mobile Carrier

## Email

I, _____, authorize Sacramento Ear, Nose & Throat and The Allergy Center to send appointment reminders and other healthcare communications electronically via email to the following email address:

_____
Email Address (Please print clearly)

## Voice Message

By signing below, I authorize Sacramento Ear, Nose & Throat and The Allergy Center to contact me for appoinment reminders and other healthcare communications via phone and voice message at the numbers provided upon registration. If I am unavailable to answer the telephone, I give Sacramento Ear, Nose & Throat and The Allergy Center permission to leave a message on my voice mail, answering machine or with the person answering the telephone. By providing additional telephone number(s) below, I give permission for same communications and permissions at this/these number(s).

_____ Please circle: Work Home
Telephone #

_____ Please circle: Work Home
Telephone #

Patient Signature _____ Date _____

OR

Parent/Legal Guardian Signature _____ Date _____

The Allergy Center at Sacramento Ear, Nose & Throat

# Appointment Cancellation | No Show Policy

Thank you for trusting your medical care to Sacramento Ear, Nose & Throat and The Allergy Center. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show policy below:

## Office Visits

Effective November 15, 2021, any patient who fails to show or cancel/reschedule an appointment less than **48 hours prior** to the appointment, will be considered a No Show or in violation of our Cancellation policy.

Upon the second No Show for our Cancellation policy, a $50 fee will be charged to the patient (we do not bill this to insurance) and will need to be paid prior to rescheduling.

Upon a third No Show or violation of our Cancellation policy, the patient may be **dismissed** from the practice.

## Surgery

If a patient scheduled for surgery fails to show, cancels or reschedules their surgery less than **1 week prior** to the scheduled surgery, the patient will be charged $100 to be paid prior to rescheduling the surgery.

**I have read and understand the Appointment Cancellation/No Show policy and agree to its terms.**

_____

Signature (Patient/Parent/Legal Guardian)

_____ _____

Print Name Date