SACRAMENTO
EAR | NOSE | THROAT
FACIAL PLASTIC SURGERY

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:** _____

Patient Information	Guarantor/Responsible Party Information	
Child's Name: First, Middle, Last	Guarantor/Responsible Party Name: First, Middle, Last	
Child's Date of Birth: ☐ Male ☐ Female	Date of Birth: ☐ Male ☐ Female	
Address (including zip):	Address: ☐ Same as child	
Home Phone: ( )	Cell Phone: ( )	
Emergency Contact Name: Relationship:	Employer: Address:	Work Phone: ( )
Phone: ( )	Relationship to Patient: (for other please specify relationship) ☐ Parent ☐ Legal Guardian ☐ Other_____	

Email: _____ **Preferred Language:** _____

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 the patients behalf to Sacramento Ear, Nose & Throat Surgical Medical Group, Inc., for any services furnished the patient by the physician. I authorize any holder of medical information about the patient 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 the patient 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. I also understand that in the event I have no insurance coverage, I am responsible for all billed charges.

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

_____ _____

Responsible Party's Signature **Date**

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Medication | Allergy Form

What is the reason for your child's visit today? _____

How tall is your child?_____ How much does your child weigh?_____

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 your child cannot take ☐ No known drug allergies

Name of Medication	Type of Reaction

Non-Medication Allergies

Has your child ever had allergy testing? ☐ No ☐ Yes

Has your child ever taken allergy shots? ☐ No ☐ Yes

Is your child currently taking shots? ☐ No ☐ Yes

Is your child allergic to any of the following? ☐ Latex ☐ Tape ☐ Foods _____

☐ Other _____

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Past Health | Social History

Please indicate any diseases that your child has had or been diagnosed with by a doctor.

☐ No Major Illnesses

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

Congenital (Birth) Problems
- ☐ Congenital Malformation
- ☐ Down Syndrome
- ☐ Prematurity (# of weeks_____)
- ☐ Cystic Fibrosis
- ☐ Other_____

Other Problems
- ☐ Acne
- ☐ Asthma
- ☐ Diabetes
- ☐ GERD/Reflux
- ☐ Sleep Apnea
- ☐ Other_____

History of any other condition not listed:
☐ _____
_____
_____

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

Has your child had surgery? ☐ No ☐ Yes _____
(Please Describe)

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.

Social History

Is your child currently attending school? ☐ Yes ☐ No What grade level?_____

Does your child use tobacco? ☐ Never ☐ Quit ☐ Yes

Does your child use any other drugs? ☐ No ☐ Not Sure ☐ Yes_____
(Please Describe)

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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 my child to carry out treatment, payment (including collection of payments), and healthcare operations. Please refer to SacENT's Notice of Privacy Practices for 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 health care operations, such as appointment reminders, insurance items, payment items, and any other information regarding my child's health care as long as they are marked "Personal and Confidential". With my consent, SacENT may e-mail any information regarding 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 child's 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 its 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's Date of Birth _____

Signature of Patient/Parent or Legal Guardian _____ Date _____

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Healthcare Communications Authorization Form

Please indicate below your preferred communication method(s) for _____
Patient's 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 appointment 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).

_____ Telephone # Please circle: Work Home

_____ Telephone # Please circle: Work Home

Patient Signature _____ Date _____

OR

Parent/Legal Guardian Signature _____ Date _____

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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)	Patient Name (if minor)/Relationship to patient
Print Name	Date