

SACRAMENTO SACRAMENTO EAR NOSE AND THROAT SURGICAL AND MEDICAL GROUP

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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
SSN:		SSN:	
Address (including zip):		Address: <input type="checkbox"/> Same as child	
Home Phone: ()		Work Phone: ()	Cell Phone ()
Emergency Contact Name:		Employer:	
Relationship:		Address:	
Phone: ()		Relationship to Patient: (for other please specify relationship) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other	
Parent/Guardian Email Address:			

Primary Insurance Information		Secondary Insurance Information	
Insurance name:		Insurance name:	
Insurance ID:		Insurance ID:	
Group or Policy Number:		Group or Policy Number:	
Policy Holders Name:		Policy Holders Name:	
Policy Holders Relationship to Patient:		Policy Holders Relationship to Patient:	
Policy Holders SSN:	Date of Birth:	Policy Holders 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 patient's behalf to Sacramento Ear Nose and 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 and 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.

Responsible Party's Signature

Date

CHILD/TEEN

Revised 0/411/2008

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 can not take

No known drug allergies

Name of Medication	Type of Reaction

Has your child ever had allergy testing?

No

Yes

Results:

Negative

Positive To:

Animals

Dust

Grass

Molds

Trees

Weeds

Is your child allergic to any of the following?

Latex

Tape

Foods _____

Other _____

Has your child ever taken allergy shots?

No Yes

Is your child currently taking shots?

No When did you stop taking shots? _____

Where they helpful? _____

Yes. When did you start shots? _____

Are they helpful? _____

Past Health History

Please indicate any diseases or problems 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's Syndrome

Prematurity (# of weeks _____)

Cystic Fibrosis

Other _____

Other Problems

Acne

Asthma

Diabetes

GERD/Reflux

Sleep Apnea

Other _____

(For Teenage Female Patients) *Are you pregnant?* Yes No Possibly / Not Sure

Please indicate any major surgeries you have had No Surgery

(If you choose other please describe)

Eyes	<input type="checkbox"/> Cataract	<input type="checkbox"/> LASIK	<input type="checkbox"/> Other
Ears	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Other	
Nose	<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Septoplasty	<input type="checkbox"/> Sinus <input type="checkbox"/> Other
Mouth / Neck	<input type="checkbox"/> Tonsil / Adenoid	<input type="checkbox"/> Thyroid Total or Partial?	<input type="checkbox"/> Other
Heart	<input type="checkbox"/> Transplant	<input type="checkbox"/> Other	
Lungs / Chest	<input type="checkbox"/> Esophagus	<input type="checkbox"/> Lungs	<input type="checkbox"/> Other
Digestive	<input type="checkbox"/> Hernia	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Other
Female/Male Health	<input type="checkbox"/> Prostatectomy Simple or Radical	<input type="checkbox"/> C-section	<input type="checkbox"/> Hysterectomy
	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Bladder	<input type="checkbox"/> Kidney <input type="checkbox"/> Other
Other	<input type="checkbox"/> Any other major surgery? Please Describe		

Family History

Please list any of your **BLOOD RELATIVES** who have a history of any of the following and give their relationship to you:

Family history unknown

Problems/Complications with Anesthesia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	RELATIONSHIP	_____
Heart Problems (Including Hypertension)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
Lungs	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
Bleeding/Clotting Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
Glands/Hormones (Diabetes)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
Other Major Health Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____
				(Please describe)
				(Please describe)

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)

Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc.
And S.E.N.T. Hearing Aid Center
Privacy Consent Form

Sacramento Ear, Nose & Throat Surgical and 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 records (Protected Health Information).

With my consent SacENT may use and disclose any Protected Health Information (PHI) about myself (or my child) to carry out treatment, payment, to collect any outstanding charges, and healthcare operations. Please refer to SacENT's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices prior to signing this consent. Our office reserves the right to revise its notice of Privacy Practices at anytime.

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, and other healthcare operations, such as appointment reminders, insurance items payment items, and any call pertaining to my clinical care, including laboratory results and information among others.

With my consent, the doctors office may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminder cards, patient statements, 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) healthcare, treatment, payment, and appointments to me.

I have the right to request that SacENT restricts how it uses and discloses my healthcare information to carry out treatment and payment. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am authorizing SacENT to use and disclose my PHI to carry out treatment, payment, and other healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SacENT may decline to provide treatment to my child or me.

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

Print Patient Name

Date of Birth

Signature of Patient or Legal Guardian

Date

The doctor may release PHI to:

- Spouse
- Partner
- Guardian

**Sacramento Ear, Nose and Throat
Surgical and Medical Group, Inc**

Patient Communication Disclosure

Please **initial** by each form of communication by which we can contact patient.

_____ The practice may **call my home or cellular phone** at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

Telephone number on which **messages** can be left: _____

_____ The practice may email **my home** or other **email address** regarding any information that will assist the practice and physician with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care.

Email Address to which information can be sent: _____

_____ The practice may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information. **Your telephone provider will charge you for this service.**

Cellular Phone to which information may be **texted:** _____

I understand that I have the right to a written request to restrict how SacENT may use or disclose my protected health information to complete treatment, payment, and health care operations. SacENT is not required to agree to my requested restrictions, but if my request is granted it is bound by that agreement. I further understand that I may revoke this authorization at any time in writing to the practice. At any time, I can change the way in which I am contacted. I have read, agree and given consent to the practice to communicate with me in the above method (s).

Patient / Legal Guardian Signature

Date