Osborne Head & Neck Institute

Patient Information

Last Name:	**First Name:**	**Middle Initial**	**Date of Birth** / /	**Age:**

Address (No PO Box Please)	**City**	**State**	**Zip**

Home Phone:	**Work Phone:**	**Cell Phone:**	**Email**

Social Security #:	Marital Status: Single Mar Div Sep Wid	**Sex: M F**

Spouses Name:	Home Phone:______________________________________ Cell Phone____

Do we have permission to leave messages that may include medical information for you at this number? Y or N

Employer:	Occupation:
Address:	City State Zip

Pharmacy Name/Address: City State Zip

____

Phone Fax

____

Have you sought legal advice for this problem? Yes or No

Primary Care Physician:

Address:	City State Zip
Phone	Fax

Insurance Information

Please give your Insurance Card to the receptionist

Primary Insurance	Policy #	Group #	Secondary Insurance	Policy#	Group#

Claims Address:	Co Pay:	Claims Address:

City State Zip	City State Zip
Subscriber's Name: / **Date of Birth:**	**Subscriber's Name:** / **Date of Birth:**
Relationship to Insured: Spouse Child Other	**Relationship to Insured: Spouse Child Other**

How Did You Hear About Us?

Website Family MD Hospital Ins Friend Other

Referring Physician:	Address:
Phone:	Fax:

Emergency Information

Emergency Contact:	**Relationship**	**Home#:**	**Cell#**

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize the release of my medical information to my referring or treating physician. I hereby authorize my Insurance Company(s) to pay directly to Osborne Head and Neck Institute or IE Surgical, the medical or surgical benefits of any otherwise payable for services as described on my insurance form hereof, but not to exceed the charges for those services. I the undersigned understand that I am financially responsible for those medical and/or surgical charges incurred by me, or my dependant. All fees necessary to collect this account are payable by me.

Signature of Patient/Legal Guardian	**Date:**

PATIENT QUESTIONNAIRE – ADULT

Name: ______________________________ **DOB:** ____________________

Date: ____________________ **Referred from:** ______________

Age: ________ **Height:** ____________ **Weight (lbs):**________ **Gender: Male / Female**

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?____
2. Have you sought legal advice for this problem? o Yes o No

PAST MEDICAL HISTORY (Please check any illnesses you have had): o None

o AIDS
o Allergies/ Hay fever
o Arthritis
o Asthma
o Bronchitis
o Cancer ______________
o Cataract disease
o Cholesteatoma
o COPD/ Emphysema
o Chronic cough
o Diabetes – insulin-dependent
o Diabetes- non-insulin dependent
o Eczema
o Glaucoma
o Headaches
o Heart disease
o Hyperthyroidisim
o Hypothyroidisim
o HIV Disease
o Joint Disease
o Laryngitis
o Migraines
o Otosclerosis
o Parotid swelling, recurrent
o Psoriasis
o Recurrent ear infections
o Recurrent sinusitis
o Recurrent throat infect
o Rosacea
o Seizures
o Skin Condition ______________
o Sleep apnea
o Snoring
o Thyroid disease
o Vasomotor rhinitis
o Other ____

PAST SURGICAL HISTORY (Please check any surgeries you have had): o None

o Adenoidectomy
o Back surgery
o Carotid artery surgery
o Ear surgery ______________
o Facelift
o Facial fracture
o Heart transplant
o Heart bypass
o Kidney transplant
o Lung surgery
o Liver transplant
o Pacemaker placement
o Parotidectomy
o Rhinoplasty
o Septoplasty
o Sinus surgery
o Thyroidectomy
o Tonsillectomy
o Turbinate reduction
o Other ______________

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): o None

a) Medication______________________Reaction______________________
b) Foods______________________Reaction______________________
c) Non Drug Allergies____
d) Do you have a history of anaphylaxis? o Yes o No
e) Do you have an allergy to latex? o Yes o No

FAMILY HISTORY (Check all illnesses that run in your family): o None

o Alcoholism
o Allergies__________
o Asthma
o Breast Cancer
o Bleeding problems
o Cancer
o Colon polyps/cancer
o COPD/emphysema
o Diabetes
o Hearing loss
o Heart attack
o High blood pressure
o Melanoma
o Migraines
o Psychiatric illness
o Sickle cell anemia
o Stroke
o Thyroid disease/cancer
o Others______________
o Do not know family history

SOCIAL HISTORY:

How many alcoholic beverages do you drink each day?______________Stopped when:____________

Do you currently smoke? o Yes o No (o cigarettes, o cigar, o pipe) Social Smoker: o Yes o No

How much, and for how long have you smoked? _______Packs per day for_____years. Stopped when:__________

Do you chew tobacco? oYes o No

Do you have any drug addictions?____

Occupation /School :______________________

Do you have an advance directive? o Yes o No

Marital status: oMarried oSingle oDivorced o Widowed

ADULT

Review of systems constitutional: (Please check all symptoms you currently have): o **None**

o Unexpected weight loss_____pounds in the past____weeks o Night sweats o Fatigue

EYES: o **None**

o Wears glasses o Swelling o Eye pain o Double vision
o Blindness o Dryness of eyes o Watery eyes o Other: ______________________________

ENT: o **None**

o Allergies o Ear pain o Hoarseness o Septal perforation o Teeth problems
o Bleeding gums o Facial pain o Mouth sores o Postnasal drip o Throat pain
o Decreased/lost smell o Gum disease o Nasal congestion o Rhinorrhea o Voice changes
o Dentures o Headaches o Nasal discharge o Ringing in ears/tinnitus o Bad breath/taste
o Difficulty swallowing o Hearing aids o Nasal obstruction o Snoring
o Dizziness/vertigo o Hearing loss o Nosebleeds o Sore throat
o Ear drainage o Heartburn o Nose pain o Sores on lips/gums
o Other ____

CARDIOVASCULAR: o **None**

o Chest pain/pressure o Palpitations o Other _____________________________________

PULMONARY/RESPIRATORY: o **None**

o Coughing blood (hemoptysis) o Shortness of breath o Other: _____________________________

GASTROINTESTINAL: o **None**

o Vomiting blood (hematemsis) o Use of antacids o Blood in stool
o Other ________________________________

MUSCULOSKELETAL: o **None**

o Back pain o Other __________________________

SKIN: o **None:**

o Change in mole o Other:__________________________

NEUROLOGICAL: o **None**

o Head trauma o Memory loss o Numbness o Syncope
o Other: ____

PSYCHIATRIC: o **None**

o Hallucinations o Suicidal thoughts o Other: _____________________________________

ENDOCRINE: o **None**

o Heat or cold intolerance o Thyroid nodule o Other: ____________________________________

HEMATOLOGY/LYMPHATIC: o **None**

o Easy bruising o Abnormal bleeding o Enlarged lymph nodes o Other: _______________________

ALLERGY/IMMUNOLOGY: o **None**

o Eye discharge o Itchy nose o Hayfever
o Itchy eyes o Rashes o Other: ______________________________________

DO YOU HAVE ANY IMPLANTABLE DEVICES? If so, what and where? _____________________________________

MEDICATIONS (List all your current medications and the dose you take): o **None** (please use back if needed)

Medication____Dose____
Medication____Dose____
Medication____Dose____
Medication____Dose____

PHARMACY

Pharmacy Name: _________________________________ Pharmacy Phone: ___________________________________

Thank you for your cooperation.

ADULT

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient/Guardian Signature: ___________________________________ Date: ________

I wish to place the following restrictions on disclosure of my health information: _______________________________

<u>Patient Financial Responsibility Agreement</u>

As a patient, it is in your best interest to know and understand your insurance plan benefits and it is your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the even that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature: ___________________________________ Date: _________

<u>Administrative Policy and Associated Fees</u>

As a courtesy to our patients, our Physicians have chosen to remain contracted with most insurance companies. In order to maintain these contracts, we will be collecting the following fees from our patients as they are applicable.

All the fees are listed below and are due at the time the services are rendered.

Appointment Cancellation Fee - $50.00
We ask that appointments be cancelled within 24 hours. Failure to notify our offices within 24 hours will result in a $50.00 charge.
Scheduling of outside referral appointments - $35.00
Occasionally a patient may be referred to have additional testing, imaging and or studies at an outside facility. If this occurs and the patient requests that our staff schedule these appointments on their behalf, there will be a $35.00 charge.
Completing Forms/Request for Letters - $50.00
In the even that a patient requests that the physician complete any forms for an outside agency or write a letter on behalf of the patient regarding his or her care, there will be a $50.00 charge.
Surgery Administrative Fee - $100.00
Prior to reserving a surgical date, a $100.00 non-refundable administrative fee will be collected. This fee covers the time and efforts associated with scheduling, confirming and coordinating your surgery, verifying insurance benefits and obtaining any necessary authorizations.
Surgery Center Deposit - $500.00
In the event that you are scheduled for surgery at our Ambulatory Surgery Center, IE Surgical, Inc., please note that a **<u>non-refundable deposit</u>** of $500.00 is required to secure your surgery date. This amount will be applied towards any surgery fees should your surgery take place. In the event that you may need to reschedule your procedure, this amount will be held as a credit for a future date. In the event that you must cancel your surgery, please inform our office within 10 business days otherwise our deposit will no longer show as a credit on your account.
Requests for Copies of Photographs/CD - $25.00
Any request for copies of patient photos and/or procedures that require CD conversion.
Requests for Medical Records - $25.00
Any request for copies of your medical records created by The Osborne Head and Neck Institute excluding copies of photographs and or DVD's that are located on the premises or stored electronically.
Chart Storage Retrieval Fee - $40.00
Our office no longer stores paper medical records. All paper medical records are stored offsite and must be retrieved. If your records need to be retrieved, there is a $40.00 fee which is due at the time of the request and takes at least 48 hrs if requested before 3pm. Additional fees apply if records are needed sooner.

I have read and understand the Osborne Head & Neck Institute's Administrative Policy and Fees, and further understand that these fees are my responsibility and I agree to pay such fees if applicable.

Patient/Guardian Signature: ___________________________________ Date: _________
Witness: _______________ (Staff Use)

Osborne Head & Neck Institute
8631 W. 3rd Street, Suite 945
Los Angeles, CA 90048
Tel (310) 657-0123 Fax (310) 657-0142

Name: ______________________________
Date of Birth: ___________________

I, the undersigned ___________________________ a patient of the Osborne Head & Neck Institute voluntarily and knowingly agree and do give my express consent to:

1. Authorize the professional staff and such assistants, photographers and technicians to take still photographs, motion pictures, produce educational (closed circuit) television programs, including video tapes, as well as other visual and/or auditory recording.
2. Permit such photograph, motion pictures, video tapes and/or auditory recordings to be published and republished in professional journals and medical books; to be used for any other purpose which the staff member may deem fit in the interest of medical education or research; and to be used at professional meeting of any kind.
3. Further authorize such photographs, motion pictures, video tapes and/or auditory records to be used for patient education.
4. Further permit the modification or retouching of such photographs and the publication of information relating to my case, either separately or in connection with publication of the photographs taken of me.
5. Although I have given permission to the publication of all details and photographs concerning my case, it is specifically understood that I will not be identified by name.

_____________________________ ________________
Patient Signature/Parent/Guardian Date:

Witness: ____________________________

This form is optional

Dear Patient,

In effort to promote convenient correspondence with our patients, we would like to request your email address. By using email, we will be able to confirm, and schedule your appointments, send you our newsletter, and provide you with current medical information. Please fill in your name, signature, and e-mail address, so we may add it to your patient file.

Thank you,

Osborne Head and Neck Institute Date: _______________

Patient's Name:_____________________________________Age: _________

Reason for your visit today: ____

Signature of Patient/Guardian: ______________________________________

E-mail: ____☐Personal ☐Work

STAFF USE ONLY:
Patient's Physician(s):____

Doctors,

Please categorize your patient, by checking off the box which relates to your patient. If patient or patient's parent may have other interests please indicate their name and mark boxes accordingly. Category suggestions are welcome.

Thank you.

- ☐ Foundation
- ☐ Gen ENT
- ☐ Cancer
- ☐ Otology
- ☐ Thyroid
- ☐ Voice
- ☐ Pediatric
- ☐ Parotid
- ☐ Laryngology
- ☐ Salivary Gland
- ☐ Entertainment
- ☐ Cosmetic
- ☐ Nose
- ☐ Sinus

Cedars-Sinai Medical Towers- 8631 W. Third St. Ste 945e, Los Angeles, CA 90048
Tel. 310-657-0123 Fax. 310-657-0142

I.E. Surgical, Inc. Endoscopy Suite

8631 W. Third St. #945E.
Los Angeles, CA 90048
310 657-0871

During your office visit, the physicians at the Osborne Head and Neck Institute may need to perform either a laryngoscopy or a nasal endoscopy to assess your medical condition. If this procedure is necessary, it will be performed in the I.E. Surgical Endoscopy Suite. The charges for the Suite will be billed to your insurance company. If your insurance company does not pay in full, you will not be billed for the balance. If you have any questions, please see the receptionist.

Informed Consent

By signing below, I have authorized the physicians at the Osborne Head and Neck Institute to perform the following if necessary: Laryngoscopy, Nasal Endoscopy. I understand that prior to the procedure, I will have all of my questions answered and the risks and benefits will be thoroughly explained to me.

Assignment of Benefits

I authorize the release of any medical or other information necessary to process my insurance claim(s). I authorize the release of my medical information to my referring or treating physician. I herby authorize my insurance company to pay directly to I.E. Surgical, Inc. the surgical and or medical benefits, if any, otherwise payable for services as described on my insurance form hereof, but not to exceed the charges for those services.

_________________________________ _____________________________

Signature Date