



SHOHET EAR ASSOCIATES

M E D I C A L G R O U P , I N C .

446 OLD NEWPORT BLVD, SUITE 100
NEWPORT BEACH, CALIFORNIA 92659
OFFICE: (949) 631-4327 FAX: (949) 631-2030

770 PACIFIC COAST HIGHWAY
SEAL BEACH, CA 90740
OFFICE: (562) 270-4327 FAX: (562) 217-4499

Name _____ Date of Birth _____
Last First MI

Single() Married() Widow() Divorced() Sex: M () F () SS# _____

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ - _____ Day Phone: () _____ - _____

Referring Physician or referring source: _____ Primary Physician: _____

Emergency contact: _____; Pharmacy: _____ City/Cross Street _____

Phone Number: () _____ - _____

Email address: _____

Who is Financially Responsible for the Bill? _____ Phone () _____

I authorize the following person(s) to discuss my medical needs/records as it relates to my care at Shohet Ear Associates:

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize Shohet Ear Associates to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I hereby authorize Shohet Ear Associates to furnish information to insurance carriers concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the Shohet Ear Associates in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature _____ **Date** _____

Parent/Custodian _____

(If Minor) _____ **Date** _____

Attestation

By initialing and dating the form below, I acknowledge that I have been given access to the Shohet Ear Associates Medical Group, Inc. Corporate Privacy Notice. (Located at www.eardoctor.org)

Signature of Pt. or Patient's Representative

Date

_____ **Initial Here** to consent to receive personally identifiable mailings from us (announcements, etc.)

_____ **Initial Here** to consent to receive personally identifiable phone calls and voicemails from us (appointment reminders, follow-ups, etc.)

_____ **Initial Here** to consent to receive E-mail correspondence from us with personally identifiable information (lab results, follow-ups, notifications, reminders, advice, etc.)

Name: _____

CHIEF COMPLAINT	
Reason(s) for Visit:	
1. _____	
2. _____	
Affected Area: _____	Family history of hearing loss: Yes <input type="checkbox"/> Who?: _____ No <input type="checkbox"/>
Height: _____ Weight: _____ Smoking: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never	
Onset of symptoms: _____ days _____ weeks _____ months _____ years	
Duration: <input type="checkbox"/> 15 mins. <input type="checkbox"/> 30 mins. <input type="checkbox"/> 1hr. <input type="checkbox"/> 2hrs. <input type="checkbox"/> Variable _____	
Frequency: <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional <input type="checkbox"/> Constant <input type="checkbox"/> Random	
Status: <input type="checkbox"/> improving <input type="checkbox"/> unchanged <input type="checkbox"/> worsening <input type="checkbox"/> resolved	
Severe of Symptoms: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> incapacitating	
Comments:	

ALLERGIES (Select any allergies & document reactions)				<input type="checkbox"/> No Allergies
<input type="checkbox"/> Accupril (quinapril)	<input type="checkbox"/> Codeine	<input type="checkbox"/> Heparin	<input type="checkbox"/> Morphine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Contrast Media (Ioversol)	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Motrin (ibuprofen)	<input type="checkbox"/> Tagamet (cimetidine)
<input type="checkbox"/> Advil (Ibuprofen)	<input type="checkbox"/> Coumadin	<input type="checkbox"/> Inderal (propranolol)	<input type="checkbox"/> Naprosyn (naproxen)	<input type="checkbox"/> Tegretol (carbamazepine)
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Darvon	<input type="checkbox"/> Indocin (indomethacin)	<input type="checkbox"/> Niacin	<input type="checkbox"/> Tetanus toxoid
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Demerol	<input type="checkbox"/> Insulin (animal)	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Augmentin (amoxicillin)	<input type="checkbox"/> Depakote	<input type="checkbox"/> Iodine or shellfish	<input type="checkbox"/> Peanut	<input type="checkbox"/> Valium (diazepam)
<input type="checkbox"/> Bactrim (sulfamethoxazole)	<input type="checkbox"/> Diamox	<input type="checkbox"/> Keflex (cephalexin)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Vancomycin
<input type="checkbox"/> Biaxin	<input type="checkbox"/> Dicloxacillin	<input type="checkbox"/> Lasix (furosemide)	<input type="checkbox"/> Percocet (oxycodone)	<input type="checkbox"/> Zithromax
<input type="checkbox"/> Ceclor (cefaclor)	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Plavix	
<input type="checkbox"/> Celebrex	<input type="checkbox"/> Egg	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Phenytoin	Other: _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Lipitor	<input type="checkbox"/> Quinolones	Reactions: _____
<input type="checkbox"/> Cipro (ciprofloxacin)	<input type="checkbox"/> Flagyl	<input type="checkbox"/> Micronase (glyburide)	<input type="checkbox"/> Ranitidine	
<input type="checkbox"/> Clinoril (sulindac)	<input type="checkbox"/> Floxin	<input type="checkbox"/> Minocin (minocycline)	<input type="checkbox"/> Septra (sulfamethoxazole)	

MEDICATIONS (List any medications you are currently taking)				<input type="checkbox"/> No Medications
Drug Name	Dosage	Frequency	Status: Chronic, Acute, Discontinued	

ENT PAST MEDICAL HISTORY (Please check all that apply)				
<input type="checkbox"/> Allergies	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Grave's disease	<input type="checkbox"/> irregular heart rate	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Speech disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Multinodular goiter	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Cancer	<input type="checkbox"/> GERD	<input type="checkbox"/> Intestinal disorder	<input type="checkbox"/> Sinus Dx	Other: _____

SURGICAL HISTORY					
Please check all that apply.	Date		Date		Date
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Colectomy	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Angioplasty w/ stent	_____	<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Septoplasty	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Ear Surgery	_____	<input type="checkbox"/> Sinus Surgery	_____
<input type="checkbox"/> Arthroscopy knee	_____	<input type="checkbox"/> Gastric bypass	_____	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Back surgery	_____	<input type="checkbox"/> Hernia repair	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Carpal tunnel release	_____	<input type="checkbox"/> Hip replacement	_____	<input type="checkbox"/> Throat Surgery	_____
<input type="checkbox"/> Cataract extraction	_____	<input type="checkbox"/> Lasik	_____	Other: _____	_____

Name: _____

ENT REVIEW OF SYSTEMS (Check only the ones you now have or have had recently)

<p align="center"><u>Constitutional</u></p> <p><input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue <input type="checkbox"/> weight gain <input type="checkbox"/> fever <input type="checkbox"/> weight loss</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Cardiovascular</u></p> <p><input type="checkbox"/> chest pain <input type="checkbox"/> heart murmur <input type="checkbox"/> palpitations</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Metabolic/Endocrine</u></p> <p><input type="checkbox"/> Cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> increased thirst</p> <p><input type="checkbox"/> other: _____</p>
<p align="center"><u>HEENT</u></p> <p><input type="checkbox"/> blurred vision <input type="checkbox"/> hoarseness <input type="checkbox"/> choking on liquids <input type="checkbox"/> mouth ulcers <input type="checkbox"/> choking on solids <input type="checkbox"/> ear pain <input type="checkbox"/> double vision <input type="checkbox"/> sore throat <input type="checkbox"/> dizziness <input type="checkbox"/> ringing in ears <input type="checkbox"/> drooling <input type="checkbox"/> vertigo <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> visual changes <input type="checkbox"/> ear drainage <input type="checkbox"/> hearing loss</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Gastrointestinal</u></p> <p><input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn <input type="checkbox"/> vomiting</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Neurological</u></p> <p><input type="checkbox"/> difficulty falling asleep <input type="checkbox"/> syncope <input type="checkbox"/> difficulty staying asleep <input type="checkbox"/> tingling <input type="checkbox"/> excessive daytime sleepiness <input type="checkbox"/> tremor <input type="checkbox"/> non-restorative sleep <input type="checkbox"/> weakness <input type="checkbox"/> numbness in extremities</p> <p><input type="checkbox"/> other: _____</p>
<p align="center"><u>Respiratory</u></p> <p><input type="checkbox"/> apnea during sleep <input type="checkbox"/> snoring <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Genitourinary</u></p> <p><input type="checkbox"/> change in urine <input type="checkbox"/> urine frequency <input type="checkbox"/> dysuria</p> <p><input type="checkbox"/> other: _____</p>	<p align="center"><u>Psychiatric</u></p> <p><input type="checkbox"/> anxiety <input type="checkbox"/> hallucinations <input type="checkbox"/> depression</p> <p><input type="checkbox"/> other: _____</p>

FEE AGREEMENT

Shohet Ear Associates Medical Group, Inc. ("We") commits to providing the undersigned ("You") with the best possible care, and will discuss our professional fees with you upon request. Your clear understanding of our financial policy is important to our professional relationship.

You are responsible for full payment of the fees billed by us. If you have health coverage, your coverage is a contract between you and your health plan ("health plan"). We do not get involved in disputes between you and your health plan regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity" or any other issues. We will supply factual and medical information as necessary and as requested.

As a courtesy, we will often attempt to collect payment from your health plan and for this purpose; you agree that any amount billed to your health plan will be assigned to us for payment.

Because cancellations and no-shows adversely affect our ability to serve our patients appropriately, we charge \$25 for any appointments that are cancelled or rescheduled with less than twenty-four hours notice. This fee is not billable to your insurance company and you will be responsible for this payment.

Private Pay

If you do not have health coverage, you must make suitable arrangements prior to the appointment; otherwise we expect payment in full at the time of service.

****Non Contracting Health Plan****

If we are not a preferred provider for your health plan, you must pay in full at the time of service. We will courtesy bill your health plan and request that it reimburse you directly.

Preferred Provider Organization (PPO) Coverage

If we are a preferred provider for your health plan, you will be responsible for your co-payment at the time of services. We will bill your health plan for the allowable amount, and we will bill you for the balance. While we contract with numerous PPOs and insurance companies, we do not guarantee that we are--or that we will remain--a contracting provider for your health plan. Some of our contracts may change. You should contact your health plan to verify that we are a contracting provider at the time of service.

Point of Service (POS) Options:

If you have chosen to exercise your POS option, this may result in: 1) reduced benefits from your insurance plan; 2) a deductible or co-payment; or 3), an inability to return to your primary care provider (PCP) for referral for procedures or surgery. Once you have decided to use the POS level of benefits, your health plan will most likely process all future bills from this office at the POS level including fees for diagnostic tests and surgery. "Retro-Authorizations" from your PCP usually cannot be accepted. You may wish to check these rules with your health insurer.

Medicare

We accept Medicare assignment.

Medicare will only pay for services that it determines are "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service, even if that service might otherwise be covered. Our determination in consultation with you that a service is reasonable and necessary may not be the same as Medicare's. Medicare also does not currently reimburse the costs of hearing aids and examinations for hearing aids (including audiograms).

If your health plan denies coverage for any reason or otherwise fails to make payment in full within forty-five (45) days, you agree to pay all bills in full.

If you delay, refuse to pay, or refute your bills, we may refer the bills to a credit collection agency or an attorney and we may report the unpaid bill to a local credit-reporting bureau.

You agree that you will pay your bills in full on time and you agree that if we reasonably need to seek the services of a collection agency or an attorney because of a dispute or non-timely payment of a bill, that you will reimburse us for the reasonable costs of collection and that the prevailing party in any dispute will be entitled to reasonable attorneys' fees. You also agree that if it is necessary to bring a legal proceeding to resolve a fee dispute, such action must be brought in a court in Orange County, California.

_____ ****Please initial if we are NOT a contracted provider for your PPO****

(initials)

By signing below, you acknowledge that you understand and agree to all of the above terms.

Patient Guarantor (Printed)

Patient Guarantor (Signature)



Medical Records Release

Authorization for Release of Medical Records to:

Shohet Ear Associates Medical Group, Inc.

446 Old Newport Blvd. Suite 100
Newport Beach, CA 92663
P: (949) 631-4327 F: (949) 631-2030

770 Pacific Coast Highway
Seal Beach, CA 90740
P: (562) 270-4327 F: (562) 217-4499

Patient Name: _____

Date of Birth: _____

Address: _____

Signature of Pt. or Representative: _____

Date: _____

Witness: _____



Dear Patient,

New legislation has recently been enacted that requires healthcare facilities to adopt an electronic medical records system as a means to report certain data points.

Shohet Ear Associates would like to assure you that your answers to these questions will have absolutely no impact on your care. You may opt to not answer by either circling or writing "Decline to Answer."

Race

- African American
- American Islander/ Alaskan Native
- Asian
- Hispanic
- Pacific Islander
- White
- Other
- Decline to Answer

Ethnicity

- Hispanic origin
- Not of Hispanic origin
- Decline to Answer

Primary Language

- English
- Other (please specify)

Thank you,

Shohet Ear Associates Team