SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

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: _____; Emergency number: ( ) _____-_____
Pharmacy: _____ City/Cross Street_____Pharmacy Phone: ( ) _____ - _____
Patient 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. _____

Height: _____Weight: _____
Affected Area(s): _____Pain Level 1-10 (10 being most severe):_____
Family history of hearing loss: Yes ☐Who?:_____ **No** ☐
Onset: _____days _____weeks _____months _____years
Duration: ☐15 mins. ☐30 mins. ☐1hr. ☐2hrs. ☐Variable_____
Frequency: ☐ Intermittent ☐Occasional ☐ Constant ☐Random
Status: ☐ improving ☐unchanged ☐worsening ☐resolved
Severity of Symptoms: ☐mild ☐moderate ☐severe ☐incapacitating
Comments:
_____

SOCIAL HISTORY

Smoking: ☐ Current ☐ Former ☐ Never

History of falling for any reason? ☐ Yes ☐ No
If yes, explain:_____

IMMUNIZATIONS

Have you received the following vaccines?
Prevnar vaccine (PCV13) ☐ Yes ☐ No date received:_____
Pneumovax vaccine (PPSV23) ☐ Yes ☐ No date received:_____
Tetanus vaccine ☐ Yes ☐ No date received:_____
Flu vaccine ☐ Yes ☐ No date received:_____

ALLERGIES ☐ No Allergies

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____

MEDICATIONS (List current medications OR attach list) ☐ No Medications

Drug Name	Dosage	Frequency	**Status:** Chronic, Acute, Discontinued

ENT PAST MEDICAL HISTORY (Please check all that apply)

☐ Allergies	☐ Congestive Heart Failure	☐ Grave's disease	☐ irregular heart rate	☐ Sleep Apnea
☐ Anemia	☐ COPD	☐ Headaches	☐ Kidney disorder	☐ Speech disorder
☐ Anxiety	☐ Coronary artery disease	☐ High Cholesterol	☐ Migraines	☐ Stomach ulcer
☐ Arthritis	☐ Depression	☐ Hypertension	☐ Multinodular goiter	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Otosclerosis	☐ Tinnitus
☐ Bleeding disorder	☐ Emphysema	☐ Hypothyroidism	☐ Seizure disorder	☐ Vertigo
☐ Cancer	☐ GERD	☐ Intestinal disorder	☐ Sinus Dx	**Other:**_____

SURGICAL HISTORY

Please check all that apply.	**Date**		**Date**		**Date**
☐ Angioplasty	_____	☐ Colectomy	_____	☐ Pacemaker	_____
☐ Angioplasty w/ stent	_____	☐ Colostomy	_____	☐ Septoplasty	_____
☐ Appendectomy	_____	☐ Ear Surgery	_____	☐ Sinus Surgery	_____
☐ Arthroscopy knee	_____	☐ Gastric bypass	_____	☐ Thyroidectomy	_____
☐ Back surgery	_____	☐ Hernia repair	_____	☐ Tonsillectomy	_____
☐ Carpal tunnel release	_____	☐ Hip replacement	_____	☐ Throat Surgery	_____
☐ Cataract extraction	_____	☐ Lasik	_____	**Other:**_____	_____

Name:_____

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

Constitutional

- ☐ chills
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss
- ☐ other:_____

Cardiovascular

- ☐ chest pain
- ☐ heart murmur
- ☐ palpitations
- ☐ other:_____

Metabolic/Endocrine

- ☐ Cold intolerance
- ☐ heat intolerance
- ☐ increased thirst
- ☐ other:_____

HEENT

- ☐ blurred vision
- ☐ choking on liquids
- ☐ choking on solids
- ☐ double vision
- ☐ dizziness
- ☐ drooling
- ☐ difficulty swallowing
- ☐ ear drainage
- ☐ hoarseness
- ☐ mouth ulcers
- ☐ ear pain
- ☐ sore throat
- ☐ ringing in ears
- ☐ vertigo
- ☐ visual changes
- ☐ hearing loss
- ☐ other:_____

Gastrointestinal

- ☐ abdominal pain
- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ vomiting
- ☐ other:_____

Neurological

- ☐ difficulty falling asleep
- ☐ difficulty staying asleep
- ☐ excessive daytime sleepiness
- ☐ non-restorative sleep
- ☐ numbness in extremities
- ☐ syncope
- ☐ tingling
- ☐ tremor
- ☐ weakness
- ☐ other:_____

Respiratory

- ☐ apnea during sleep
- ☐ shortness of breath
- ☐ snoring
- ☐ wheezing
- ☐ other:_____

Genitourinary

- ☐ change in urine
- ☐ dysuria
- ☐ urine frequency
- ☐ other:_____

Psychiatric

- ☐ anxiety
- ☐ depression
- ☐ hallucinations
- ☐ other:_____

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.

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)(l) 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)

SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

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: _____

Print Name of Patient/Representative: _____

Date: _____

Witness: _____

SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

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.
ENT Specialists of Orange County 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!