SONORAN
Ear • Nose • Throat

THOMAS KANG, MD R. JONATHAN LARA, DO AMANDA KESTER, AUD

MEDICAL HISTORY FORM

FULL NAME: First | Middle (Opt.) | Last

DATE OF BIRTH: **TODAY'S DATE:**

CHIEF COMPLAINT (REASON FOR VISIT):

HEIGHT (INCHES) **WEIGHT (LBS):**

PAIN LEVEL (0-NO PAIN TO 10-WORST PAIN OF LIFE):

ALLERGIES: ☐ None Known

DRUG NAME	REACTION (E.G., RASH)	SEVERITY (LEVEL 1-MILD TO LEVEL 4-SEVERE)
1)		
2)		
3)		
4)		
5)		

MEDICATIONS ☐ IF MORE SPACE NEEDED, CHECK HERE AND USE BACK OF SHEET

DRUG NAME:	DOSAGE	FREQUENCY
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PAST MEDICAL DIAGNOSES (E.G., HYPERTENSION):

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

PAST SURGICAL HISTORY ☐ IF MORE SPACE NEEDED, CHECK HERE AND USE BACK OF SHEET

SURGERY TYPE (E.G., TONSILLECTOMY)	Date/Location
1)	
2)	
3)	
4)	
5)	
6)	

ANESTHESIA HISTORY: ☐ No Complications ☐ Prior Complication _____☐
Family History of Complications _____

SOCIAL HISTORY:

TOBACCO USE: ☐Never ☐Former (Quit when _____) ☐ Light User ☐ Heavy User

ALCOHOL USE: ☐ Yes (drinks per day_____) ☐ No

DRUG USE: ☐ Yes ☐ No

CAFFEINE USE: ☐ Yes (drinks per day _____) ☐ No

OCCUPATION: _____

FAMILY HISTORY: ☐ Unknown

RELATIVE	Medical Condition(s)
1)	
2)	

REVIEW OF SYSTEMS ☐ None Apply

Ear	Nose	Throat	Resp
☐ Pain	☐ Drainage	☐ Hoarseness	☐ Cough
☐ Drainage	☐ Congestion	☐ Swallowing Issues	☐ Difficulty Breathing
☐ Hearing Changes	☐ Odor	☐ Sore throat	☐ Wheezing
☐ Dizziness	☐ Pain	☐ Snoring	☐ Coughing up blood
☐ Tinnitus/Ringing	☐ Bloody Nose	☐ Dry Mouth	
☐ Pressure	☐ Loss of smell		
Cardiovascular	**Gastrointestinal**	**Genitourinary**	**Constitutional**
☐ Chest Pain	☐ Bowel Problems	☐ Painful urination	☐ Fevers
☐ Irregular Heart Beat	☐ Heartburn	☐ Difficulty Urinating	☐ Weight Loss
☐ Bleeding Disorder	☐ Diarrhea		☐ Fatigue
			☐ Night Sweats
Neurologic	**Skin**	**Psychiatric**	**Musculoskeletal**
☐ Headaches	☐ Skin Growths	☐ Depression	☐ Joint Pain
☐ Seizures	☐ Changing Mole	☐ Anxiety	☐ Joint Swelling
☐ Numbness	☐ Dry/Itchy Skin	☐ Sleep Disturbances	☐ TMJ Syndrome
☐ Blurred Vision	☐ Rash	☐ Stress	
☐ Double Vision			

PHARMACY

PHARMACY NAME: _____

PHARMACY ADDRESS OR CROSS STREETS: _____

PHARMACY PHONE NUMBER (IF KNOWN): _____

PROVIDER INFORMATION

PRIMARY CARE PHYSICIAN/PROVIDER: _____

REFERRING PHYSICIAN IF DIFFERENT: _____

HOW DID YOU HEAR ABOUT SONORAN EAR NOSE AND THROAT? _____

SIGNATURE: _____ Date:_____

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PATIENT INFORMATION

FULL NAME: First Middle (Opt.) Last

DATE OF BIRTH: **TODAY'S DATE:**

SEX: ☐Male ☐Female

SOCIAL SECURITY #:

MOBILE PHONE: ☐ I do not have a mobile phone

MAY SEND MOBILE TEXT NOTIFICATIONS? ☐Yes ☐No

MAY SEND VOICE NOTIFICATIONS? ☐Yes ☐No

EMAIL ADDRESS:

MAY SEND EMAIL NOTIFICATIONS? ☐Yes ☐No

HOME PHONE:

WORK PHONE:

PREFERRED METHOD OF CONTACT? ☐Home Phone ☐Mobile ☐Email ☐Mail ☐Work Phone

HOME ADDRESS:

CITY/STATE/ZIP:

PAYMENT INFORMATION

☐ **SELF PAY, CHECK HERE AND SKIP TO DEMOGRAPHICS**

PRIMARY INSURANCE

POLICY HOLDER NAME:

POLICY HOLDER ADDRESS:

POLICY HOLDER DATE OF BIRTH: **POLICY HOLDER SS#:**

POLICY HOLDER PHONE NUMBER:

INSURANCE NAME:

POLICY ID #: **GROUP #:**

EFFECTIVE DATE:

RELATIONSHIP TO INSURED: ☐Self ☐Spouse ☐Child ☐Other

EMPLOYER NAME:

EMPLOYER ADDRESS:

CITY/STATE/ZIP:

SECONDARY INSURANCE

POLICY HOLDER NAME: _____

POLICY HOLDER ADDRESS: _____

POLICY HOLDER DATE OF BIRTH: _____ **Policy Holder SS#:** _____

POLICY HOLDER PHONE NUMBER: _____

INSURANCE NAME: _____

POLICY ID #: _____ **GROUP #:** _____

EFFECTIVE DATE: _____

RELATIONSHIP TO INSURED: ☐Self ☐Spouse ☐Child ☐Other

DEMOGRAPHICS

PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other, Please Specify: _____

RACE: ☐White ☐African American ☐American Indian/Alaska Native ☐Pacific Islander ☐Asian ☐Other/Choose not to specify

ETHNICITY: ☐Hispanic or Latino ☐Non Hispanic or Latino

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Sonoran Ear Nose and Throat. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

SIGNATURE: _____Date: _____

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Financial Policy

Welcome to our office! We are pleased that you have chosen Sonoran Ear Nose and Throat to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept cash, personal checks, and credit cards for payment on your account. If you have insurance, which we do not contract with, you will be expected to make a full payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay and deductible at the time of your visit.

COMMERCIAL/PRIVATE INSURANCE: As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

CONTRACTED INSURANCE: We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

_____ **In the event Sonoran Ear Nose and Throat is not contracted with your health plan, you will be responsible for any out of network, coinsurance, or deductible applied.**

Initial here

NO INSURANCE: If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

MEDICARE: We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance at the time of service.

NO SHOW FEE: In the event your appointment is not canceled 24 hours in advance and/or you do not show for your appointment, there will be a $25.00 fee assessed to your account.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a $25.00 return check fee charged to your account.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You!

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Sonoran Ear Nose and Throat and have provided to the best of my ability the information requested accurately and completely.

_____ _____

Patients/Responsible Party Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of Sonoran Ear Nose and Throat Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement,** but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____

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Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records
_____ Lab results/X-ray reports
_____ Physical exam
_____ Consultation reports
_____ Immunization record
_____ Other (please specify: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following individual or organization.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:
Privacy Officer of Sonoran Ear Nose and Throat

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

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Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave a detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system or with a trusted family member. It should be noted that our current notice of privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s). Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it.

Please choose one of the following:

□ **I DO CONSENT** for Sonoran Ear Nose and Throat and his staff to leave detailed messages:

I, _____ give Sonoran Ear Nose and Throat permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

□ Answering machine_____Initials _____
□ My cell phone_____Initials _____
□ Spouse (name) _____
Phone number(s) _____Initials _____
□ Other (name) _____
Phone number(s) _____Initials _____
□ Other (name) _____
Phone number(s) _____Initials _____

Signature _____ Date _____

□ **I DO NOT CONSENT** to leave detailed messages on my phone or answering machine or with any member of my family.

Signature _____ Date _____

□ **REVOCATION OF PRIOR CONSENT:** I wish to rescind or stop the above authorizations.

Signature _____ Date _____

If not signed by patient, please indicate your relationship to the patient _____

Print Patient Name: _____ Date of Birth _____