Thomas S. Kang, MD
R. Jonathan Lara, DO
Ramona Toy, FNP-C
William Kluge, FNP-C
Sarah Lim, FNP-C

SONORAN EAR NOSE THROAT AUDIOLOGY

Amanda Kester, AuD
Beth Benites, AuD
Jamie Landau, AuD
Emily Walker, AuD
Stacey Trepanier, AuD
Yesenia Castillo, AuD
Matthew Mutterperl, AuD

MEDICAL HISTORY FORM

FULL NAME: _____

FIRST MIDDLE (optional) LAST

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

HEIGHT (inches): _____ **WEIGHT (lbs):** _____

CHIEF COMPLAINT (reason for visit): _____

_____

MEDICATION ALLERGIES: [ ] CHECK IF NONE KNOWN

	MEDICATION NAME	REACTION	SEVERITY (LEVEL 1-MILD TO 4-SEVERE)
1)			
2)			
3)			
4)			
5)			

MEDICAL DIAGNOSES: (e.g. Hypertension, Asthma, Diabetes, etc.; Why are you taking the medications below?)

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

MEDICATIONS: [ ] CHECK BOX IF MORE SPACE IS NEEDED, AND USE BACK OF SHEET

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

PAST SURGICAL HISTORY [ ] CHECK BOX IF MORE SPACE IS NEEDED, 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 date:) [ ] LIGHT USER [ ] HEAVY USER

ALCOHOL USE: [ ] NO [ ] YES (drinks per day: _____) [ ] SOCIAL

DRUG USE: [ ] NO [ ] YES - MARIJUANA [ ] YES - OTHER

CAFFEINE USE: [ ] NO [ ] YES (drinks per day: _____)

OCCUPATION: _____

REVIEW OF SYSTEMS [ ] CHECK IF NONE APPLY

EAR	NOSE	THROAT	RESPIRATORY
☐ 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		

PREFERRED PHARMACY

PHARMACY NAME:

PHARMACY ADDRESS OR CROSS STREETS:

PHARMACY PHONE NUMBER:

PROVIDER INFORMATION

PRIMARY CARE PROVIDER:

REFERRING PROVIDER:

HOW DID YOU HEAR ABOUT US?:

SIGNATURE: _____ **DATE:** _____

Thomas S. Kang, MD
R. Jonathan Lara, DO
Ramona Toy, FNP-C
William Kluge, FNP-C
Sarah Lim, FNP-C

SONORAN EAR NOSE THROAT AUDIOLOGY

Amanda Kester, AuD
Beth Benites, AuD
Jamie Landau, AuD
Emily Walker, AuD
Stacey Trepanier, AuD
Yesenia Castillo, AuD
Matthew Mutterperl, AuD

PATIENT INFORMATION

FULL NAME: _____

FIRST **MIDDLE (optional)** **LAST**

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

PREFERRED NAME: _____

SEX: [ ] Male [ ] Female [ ] N/A [ ] Other: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

MOBILE PHONE: _____ **HOME PHONE:** _____ **WORK PHONE:** _____

EMAIL ADDRESS: _____

PREFERRED METHOD OF CONTACT: [ ] MOBILE [ ] HOME [ ] WORK [ ] EMAIL [ ] MAIL

DEMOGRAPHICS

PREFERRED LANGUAGE: [ ] English **[ ]** Spanish **[ ]** Other (please specify): _____

RACE: [ ] White **[ ]** African American **[ ]** American Indian/Alaska Native **[ ]** Asian

[ ] Pacific Islander **[ ]** 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: _____

SIGNATURE: _____ **DATE:** _____

Thomas S. Kang, MD
R. Jonathan Lara, DO
Ramona Toy, FNP-C
William Kluge, FNP-C
Sarah Lim, FNP-C

SONORAN EAR NOSE THROAT AUDIOLOGY

Amanda Kester, AuD
Beth Benites, AuD
Jamie Landau, AuD
Emily Walker, AuD
Stacey Trepanier, AuD
Yesenia Castillo, AuD
Matthew Mutterperl, AuD

FINANCIAL POLICY

Welcome to our office! We are pleased that you have chosen Sonoran Ear, Nose, Throat, Audiology 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 copay 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 copay 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 copay 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.

_____
Initial here

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

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 copays/coinsurance at the time of service.

RETURNED CHECKS: In the event your bank returns your check to our office, 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, Throat, Audiology and have provided to the best of my ability the information requested accurately and completely.

_____ _____
Patient / Responsible Party Signature **Date**

Thomas S. Kang, MD
R. Jonathan Lara, DO
Ramona Toy, FNP-C
William Kluge, FNP-C
Sarah Lim, FNP-C

SONORAN EAR NOSE THROAT AUDIOLOGY

Amanda Kester, AuD
Beth Benites, AuD
Jamie Landau, AuD
Emily Walker, AuD
Stacey Trepanier, AuD
Yesenia Castillo, AuD
Matthew Mutterperl, AuD

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 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.

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.

PLEASE CHOOSE AND CHECK ONE OF THE FOLLOWING:

[ ] I DO CONSENT for Sonoran Ear, Nose, Throat, Audiology and its staff to leave detailed messages:

I, _____ give Sonoran Ear, Nose, Throat, Audiology 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_____