



INSTRUCTIONS: Please check if you currently have any of the following symptoms.

CONSTITUTIONAL:

Recent unexplained weight loss

EYES:

Double vision

HEART:

Chest pain

LUNGS:

Coughing up blood

GI:

Vomiting

GU:

Blood in urine

NEUROLOGICAL:

Loss of consciousness

PSYCHIATRIC:

Hallucinations

HEMATOLOGY:

Easy bleeding

ALLERGIC:

Anaphylaxis

None of the above

Thank you for completing this questionnaire. If you have any questions about any of the above items, please ask your physician at the time of your appointment.

Signature (Patient or Legal Guardian): _____ Date: _____

STAFF USE ONLY:

Provider Signature: _____
I have personally reviewed the above history.



New Patient Information (Age 12 & Under)

Name _____ Date _____

Your Name _____ Relationship to Patient _____

	Parent(s)/Legal Guardian(s)	Relationship to Patient	Custody?
(1)	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
(2)	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

Pediatrician _____

Allergies to Medications _____

Environmental or Food Allergies _____

Routine Medications And Dosages _____

Other Medications Taken In Last Month _____

List All Past Surgeries (type and approximate year) _____

Birth History Born at _____ weeks weight _____ c section vaginal delivery

Complications during pregnancy or delivery? _____

Newborn Hearing Screen Performed? yes no If yes, result was: pass refer

Past and Current Medical History (check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> autism | <input type="checkbox"/> hearing loss | <input type="checkbox"/> speech delay | <input type="checkbox"/> cleft lip or palate |
| <input type="checkbox"/> NICU stay | <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> asthma | <input type="checkbox"/> other lung problems | <input type="checkbox"/> sickle cell |
| <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> kidney problems | <input type="checkbox"/> migraines | <input type="checkbox"/> cancer |
| <input type="checkbox"/> other _____ | | | |

Immunizations had all recommended immunizations had some had none

Family History (check all that apply)

- | | | | | |
|---------------------------------------|--------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> allergies | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> cancer |
| <input type="checkbox"/> migraines | <input type="checkbox"/> other _____ | | | |

Social History

In daycare or school? yes no Secondhand smoke exposure? yes no

Household members/siblings (ages) _____

After the information above has been transferred to your electronic medical record, this worksheet is securely destroyed



Today's Date: _____

AUTHORIZATION FOR ELECTRONIC TRANSMISSION OF PROTECTED HEALTH INFORMATION AND USE OF ELECTRONIC COMMUNICATIONS

Name: _____

Date of Birth: _____

Medical Record Number: _____

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment. For other than test results, a valid HIPAA compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes, or electronic mail. To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related HIV, Hepatitis, substance abuse, or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, FAX, e-mail, MyCSLink).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, e-mail address, telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information, as well as regarding account information or other information pertinent to medical services. You also are agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

I authorize physicians and/or staff to contact me via the following:

FAX Number: _____

Telephone Voicemail: _____

E-mail Address: _____
(E-mail is not an option available from all medical offices)

Name of Alternative Person I Elect to Receive My PHI:

Phone Number:

Address:

Signature: (Patient or individual legally authorized to consent to release)

Date:

This authorization shall remain in effect until you are notified by me in writing of any changes.

The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-7058.



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A Notice to Our Valued Patients

During your visit in our ENT department, your physician may find it necessary to use endoscopes (special lighted instruments) as part of his evaluation. This will enable your physician to provide you with the most thorough examination of your sinuses and throat when needed. Although, this is fairly routine for our specialty, most insurance companies consider this a “Surgery” or “In- office Procedure” and it may be reflected as such on your billing statement or explanation of benefits. In addition, your physician may also require you to have an Audiogram, also known as a hearing test. Each of these services will result in an additional charge and therefore an additional financial responsibility for you. We want you to be informed of these services so there are no surprises or concerns after you leave our office.

Please sign below to acknowledge that you received the office notification regarding office Endoscopies/Audiograms and are aware that it may be performed during your visit.

Patient/Guardian

Date

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Los Angeles, CA 90048