_____ ☐ S ☐ PS

Provider Signature: I have personally reviewed the below history.

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

SKIN:

☐ Rash

☐ **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: _____

CEDARS-SINAI
MEDICAL GROUP

Pediatric & Adult Ear, Nose & Throat
Otolaryngology, Head & Neck Surgery

New Patient Information (Age 13 & Older)

Name_____ **Date** _____

Occupation _____ **Employer** _____

Primary Care Physician (PCP) _____

Referring Physician _____

Reason for Visit _____

Past and Current Medical History (check all that apply)

□ Acid Reflux (GERD) □ Cancer (type, year)_____ □ Hepatitis □ Migraines

□ Asthma □ COPD/Emphysema □ High blood pressure □ Osteoporosis

□ Blood Clot □ Diabetes □ HIV □ Sleep Apnea

□ Bleeding Disorder □ Heart/Lung Disorder: _____ □ Stroke

□ Other _____

Past Surgeries (type and approximate year) _____

_____

_____

Allergies (Environmental, Food, Medications)_____

Routine Medications And Dosages_____

_____

_____

Please check the boxes below if you have any family history of the following diseases. Please fill in who in your family was affected.

□ Allergies_____ □ Bleeding Disorder_____ □ Cancer_____Type of Cancer_____

□ Early Hearing Loss_____ □ Heart Disease_____ □ Migraines_____ □ Thyroid_____

□ Other _____

Social History

Have you ever smoked tobacco?	□ yes	□ no	if yes,_____packs/day for_____years
Have you quit?	□ yes	□ no	if yes, how long ago?_____
Have you ever used chewing tobacco?	□ yes	□ no	
Do you drink alcohol?	□ yes	□ no	if yes,_____drinks per day / week / month

Other substance use? _____

Upcoming Travel or Major Family Events _____

Cedars-Sinai Medical Office West Tower
8635 West 3rd Street, Suite 590 W
Los Angeles, CA 90048

Cedars-Sinai Medical Office East Tower
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CEDARS-SINAI®

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