

Desert Ear, Nose & Throat

The offices of:

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(Cross street Highway 111 and Dunes View Road)

71687 Highway 111, Suite 101

Rancho Mirage, CA 92270

Telephone: (760) 340-4566

Fax: (760) 340-2481

Web Address: www.desertent.org

Office Hours:

Monday – Friday 8:30 A.M. – 4:00 P.M.

Enclosed are the new patient forms. Once you have completed all the paperwork, please bring them to your appointment along with your insurance card(s) and a list of medication you may be taking. We ask that you arrive 15 minutes prior to your scheduled appointment time so we can process your paperwork and check you in.

Thank you.

Desert Ear, Nose, & Throat

DO NOT FAX PAPERWORK. HAND CARRY TO APPOINTMENT

Today's Date: _____

OFFICE USE ONLY:

DR: _____

NEW DELETE UPDATE EMR

IF DELETED PATIENT:

Last seen: _____

By Dr: _____

PLEASE PRINT CLEARLY

Personal Information (PLEASE FILL OUT ALL INFORMATION)

Government requirement for Electronic Health Care reporting

Preferred language: English Spanish Other: _____

Race: White African American American Indian or Alaska Native Asian
 Native Hawaiian or Other Pacific Islander decline

Ethnicity: Hispanic/Latino Non -Hispanic/Latino decline

Patient Name: _____ Birth Date _____ Age: _____ Sex: _____
(nombre) (Last) (First) (MI) fecha de nacimiento (edad) (sexo)

Mailing & Street Address: _____
(domicilio)

City: _____ State: _____ Zip _____
(ciudad) (estado) (codigo postal)

Local Phone#: _____ Work Phone: _____ Cell Phone: _____
(telefono de casa) (telefono de trabajo) (telefono de celular)

Social Security#: _____ - _____ - _____ (we need your SS# for any testing requested by physician)
(seguro social) (es necesario para procesar sus exámenes de laboratorio o biopsias)

Emergency Contact: _____ Relationship: _____ Phone: _____
(Contacto de emergencia) (relacion) (telefono)

2nd address (if applicable)

E-MAIL ADDRESS: _____

Employment and/or Insurance Information (If patient is a minor we need guardians information)

Employer: _____
(Nombre de Empleador)

Insurance: _____ Policy Holders Name: _____
Aseguranza (nombre del asegurado)

SSN: _____ DOB: _____ Relationship to Patient: _____
(Seguro social) (fecha de nacimiento) (relacion al paciente)

Date of Visit: _____

Patient's Name: _____ Birth Date: _____ Age: _____

Primary Care Physician (FIRST/LAST NAME) _____	City/State/ Phone: _____
Cardiologist (if any): _____	City/State/phone: _____

Physician Requesting Consult: _____ City & State: _____

[1] Reason for Your Visit: _____

[2] SYSTEM REVIEW: (check all that apply)

- Constitutional: fever unexpected weight loss
- Eyes: double vision eye pain
- Ears: hearing loss ear pain
- Throat: throat pain hoarseness
- Cardiovascular: chest pain irregular heart rate
- Respiratory: bloody cough snoring/apnea
- Gastrointestinal: heartburn difficulty swallowing
- Genitourinary: urinary blood difficulty urinating
- Musculoskeletal: joint pain muscle loss
- Skin: itching skin lesions
- Neurological: tremors numbness
- Psychiatrics: anxiety panic attacks
- Endocrine: heat /cold intolerance thyroid nodule
- Hematologic: clotting disorders anemia
- Allergy: sneezing immune system disorders

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- Diabetes High blood pressure Heart disease
- Stroke Asthma/Lung disease Bleeding Disorder
- Stomach/Intestinal/Ulcers Kidney Prostate
- Glaucoma Tuberculosis
- Need to take antibiotic: before seeing dentist
- Cancer (Please Specify) _____
- Other: (Please specify) _____

PAST SURGICAL HISTORY: (check all that apply)

- Ear Surgery Please specify: _____
- Tonsils/Adenoid Surgery
- Appendectomy
- Gallbladder Surgery
- Hernia Repair
- Hysterectomy
- Thyroidectomy
- Pacemaker Placement
- Eye Surgery. Please specify: _____
- Cosmetic Surgery Please specify: _____
- Sinus Please Specify: _____
- Other: _____

PLEASE PROVIDE CURRENT MEDICATION LIST (include dose & frequency):

- Aspirin Coumadin Plavix Xarelto Eliquis
- _____
- _____
- _____
- _____
- _____

DRUG ALLERGIES & REACTIONS

Have you had your flu vaccine? Yes No
If yes, when: _____

Have you had your COVID-19 vaccine? Yes No
If yes, when: _____

Preferred Pharmacy and Location (Cross Street & Zip Code)

Do you authorize our practice to access your prescription history through your insurance company? Yes No

[4] SOCIAL HISTORY:

Marital Status: Single Married Domestic Partner
 Divorced Widowed

Type of work: _____
How much do you smoke daily? _____
If you smoked in the past, when did you quit? _____
History of heavy alcohol use? YES NO
How much alcohol do you drink daily? _____
Street Drugs? _____

FAMILY HISTORY: Do any of your relative have:

- Bleeding Disorder Early Hearing Loss Vertigo
- Thyroid Cancer
- If "YES", specify which relative: Mother Father Sister
- Brother Grandmother Grandfather
- Other: _____

OFFICE POLICIES

DESERT EAR, NOSE AND THROAT OFFICE POLICIES

Desert Ear Nose and throat has taken steps to optimize our administrative operations in order to spend more time on patient care. We are deeply committed to the highest quality of patient care and are here to make your experience as pleasant as possible. In order to be successful, we will require your help and cooperation.

Please read our office policies as they are strictly enforced

- In order to serve our patients better, we have instituted a *cancellation policy*. If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment. If you do not cancel 24 hours in advance you will be charged a no-show fee of \$30.00
- Know your insurance plan and what your benefits are. If we are not a contracted provider with your insurance we will ask for payment at time services are rendered, however, as a courtesy, we will bill your insurances company. You will be responsible for any remaining balance your insurance company did not cover.
- Co-payments and deductibles are due at the time of service.
- There will be a \$36.00 fee for all returned checks (NSF)
- Refill requests should be made through your pharmacy. Please allow 24 - 48 hours for all refill requests to be processed, *excluding weekends and holidays.*
- If your physician has ordered tests, *it is your responsibility to call our office for results.* Do not assume that your tests are negative because your physician has not called you. Please allow three business days for turnaround time for your results.
- You must update our practice with any new insurance and/or demographic information as soon as possible.
- There is a 48 - 72 hour turnaround time for medical records. There will be up to a \$25.00 fee that due at the time the request is made. If the records are in storage the fee is \$8.00 in addition to the record copy fee.
- There will be a fee up to \$25.00 charge for the first disability; social security forms \$15.00 thereafter for any additional form(s).
- If you call and leave a message for your physician, we ask that you be patient. All phone calls are returned by the end of the business day. ***IF YOU ARE NOT AVAILABLE, THE PHYSICIANS/STAFF MAY LEAVE A MESSAGE ON A MACHINE REGARDING YOUR REQUESTS, RESULTS, OR HEALTH INFORMATION (unless you decline, see below)***
- *Authorization for release of medical information.* I hereby authorize Desert Ear, Nose and Throat to release any and all medical records to my insurance company in order to process this or any future medical claims with this office.
- *Financial Policy:* I understand that I am financially responsible for payment due at the time services are rendered by Desert Ear, Nose & Throat. This includes payment in full or any deductibles, co-payment and co-insurance amounts which apply at the time of services.
- The physicians/staff at Desert Ear Nose & Throat are given the authority, by the patient/guardian, to leave a message on a machine in the event you are not available, The message, may pertain to results, health information, appointments and/or any other information that you may have discussed with your physician. **IF YOU AUTHORIZE FOR DESERT EAR NOSE AND THROAT TO LEAVE A MESSAGE ON A MACHINE OR TO SPEAK WITH ANYONE OTHER THAN YOURSELF, INITIAL HERE:** _____

(Initial)

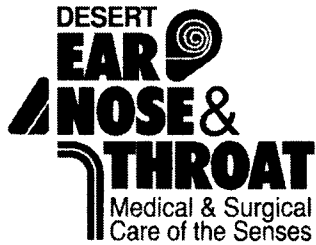
If you **DO NOT** wish for Desert Ear Nose and throat to leave a message on a machine or to speak with anyone other than yourself initial here: _____

(Initial)

Patient Name (please print)

Patient and/or Guardian Signature

Date:



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PRIVACY PRACTICES ACKNOWLEDGMENT NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used along the following guidelines:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization and any time at: Desert Ear, Nose & Throat 39000 Bob Hope Drive, W301, Rancho Mirage, CA 92270 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment and or healthcare operations. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print)

Relationship to patient:

Signature of patient/guardian

FINANCIAL INTEREST DISCLOSURE

Please be advised that certain physician employees of Eisenhower Balance Institute are also owners and have a financial interest in the following facilities:

Hearing Institute of the Desert 71-687 Highway 111, Suite 205 Rancho Mirage, CA 92270	Rancho Mirage Surgery Center 35800 Bob Hope Drive Suite 100 Rancho Mirage, CA 92270
Desert Ear Nose & Throat 71-687 Highway 111, Suite 101 Rancho Mirage, CA 92270	X-Ray Computed Tomography (CT SCAN) at Desert Ear, Nose & Throat 71-687 Highway 111, Suite 101 Rancho Mirage, CA 92270

You may be referred to the Hearing Institute of the Desert, Rancho Mirage Surgery Center, Desert Ear Nose and Throat or the X-Ray Computed Tomography to obtain medical services and/or equipment that each of these facilities offers. You have absolutely no obligation to obtain medical services and/or equipment from these facilities. There are medical practitioners and competing businesses other than these facilities that can provide you the same type of services and/or equipment.

(Name of patient – PLEASE PRINT)

(Patient or legal guardian signature)

(Date)

MEDICARE & MEDICARE/MEDI-CAL ASSIGNMENT OF BENEFITS

Name: _____ Medicare#: _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Eisenhower Balance Institute for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

IMPORTANT INFORMATION, PLEASE READ

Eisenhower Balance Institute, (this location), is not a Medi-cal provider. You will be responsible for your co-insurance/deductibles after Medicare's payment for services done at this location, all co-pays/co-insurance are due at the time of service

(Signature)

(Date)