

# REGISTRATION FORM

(Please Print)

Today's Date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )	
P.O. box:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )	
Chose clinic because/referred to clinic by (Please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

<b>INSURANCE INFORMATION</b>						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Aetna <input type="checkbox"/> Cigna	
<input type="checkbox"/> Great West	<input type="checkbox"/> CCN	<input type="checkbox"/> Beech Street	<input type="checkbox"/> Schaller Anderson	<input type="checkbox"/> Other _____		
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pacific E.N.T. Medical Group, Inc. or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

**PACIFIC ENT MEDICAL GROUP  
MEDICAL HISTORY RECORD  
CYNTHIA R. DAVIS, M.D., F.A.C.S.**

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Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI, Suffix

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

Reason for present visit: \_\_\_\_\_

**MEDICAL/SURGICAL HISTORY**

Please list any significant medical problems or illnesses, past (with dates) or present:

\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies/reactions to medications (if none, please indicate):

\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications (include over the counter medications and herbal supplements):

\_\_\_\_\_  
\_\_\_\_\_

Please list any operations you have had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any serious accidents or injuries: \_\_\_\_\_

**SOCIAL HISTORY**

Do you or have you ever:

Smoked?	N	Y	_____ pack(s)/day for _____ yrs.	Still smoking? _____	Quit _____
Drink alcohol?	N	Y	Type/amount per week _____	Still drinking? _____	Quit _____
Chewed tobacco?	N	Y	How often? _____	Still using? _____	Quit _____
Abused drugs?	N	Y	Please describe _____	Last use _____	

**FAMILY HISTORY**

Please provide the following information with regard to your relatives:

If living, age, state of health/illnesses; If deceased, age and cause of death

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Children \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Family \_\_\_\_\_  
\_\_\_\_\_

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(Medical History cont.)

## Review of Systems

Please indicate if you recently or routinely experience any of the following symptoms:

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If checked, please describe

### ***General***

- Fevers/Chills \_\_\_\_\_
- Weight Loss/Gain \_\_\_\_\_
- Headaches \_\_\_\_\_
- Visual trouble \_\_\_\_\_
- Seizures \_\_\_\_\_
- Loss of consciousness \_\_\_\_\_
- Wheezing \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Cough \_\_\_\_\_
- Chest pain \_\_\_\_\_
- Abdominal Pain \_\_\_\_\_
- Nausea/Vomiting \_\_\_\_\_
- Heartburn/Indigestion \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Urinary dysfunction \_\_\_\_\_
- Psychiatric Disorder \_\_\_\_\_
- Muscle weakness \_\_\_\_\_
- Stiff joints \_\_\_\_\_
- Bleeding tendencies \_\_\_\_\_
- Rash or skin disorder \_\_\_\_\_
- Other \_\_\_\_\_

### ***Ear, Nose & Throat***

- Hearing loss \_\_\_\_\_
- Ringing in the ears \_\_\_\_\_
- Dizziness/Vertigo \_\_\_\_\_
- Pain in the Ears \_\_\_\_\_
- Ear Discharge \_\_\_\_\_
- Nasal Discharge \_\_\_\_\_
- Nasal Obstruction \_\_\_\_\_
- Nosebleeds \_\_\_\_\_
- Sinusitis \_\_\_\_\_
- Allergic symptoms \_\_\_\_\_  
(Sneezing/itchy eyes)
- Post Nasal Drip \_\_\_\_\_
- Difficulty Swallowing \_\_\_\_\_
- Vocal Changes \_\_\_\_\_
- Snoring \_\_\_\_\_

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\_\_\_\_\_  
Patient Signature

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\_\_\_\_\_  
Date

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(For internal use)

I have reviewed and confirmed the above with the patient \_\_\_\_\_

# Notice of Privacy Practices

This is a summary of the Notice of Privacy Practices, which describes how we may disclose your medical and personal information and how you can have access to this information. We have attached a full version of the notice.

## Our Pledge to Protect your Privacy

We are committed to protecting the privacy of your medical and personal information. So we can best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your health information for any other purpose without your permission.

## Your Rights Regarding your Medical Information

- To inspect and obtain a copy of your medical records with certain limitations.
- To request an amendment or addendum to your medical record.
- To an accounting of disclosures of your medical information.
- To request restrictions on certain uses and disclosures of your medical information.
- To request when and where to contact you,
- To request a copy of the full version of this document our Privacy Practices.

## We may use and disclose your personal and health information without your authorization for the following purposes

- To provide you with medical treatment.
- To bill and receive payment for the treatment received.
- As required and permitted by law.
- For functions necessary to assure that our patients receive quality care.
- For public health activities (e.g. reporting abuse).
- For research purposes in limited circumstances.
- To the coroner, medical examiner, funeral director or organ procurement organization for certain purposes.
- To a court or administrative order, subpoena, discovery request or other lawful process.
- To a health oversight agency, such as the Department of Health Services.

We reserve the right to change our privacy practices and update this notice accordingly.  
I have read and understand my rights of Pacific E.N.T. Medical Group's Privacy Standards.

\_\_\_\_\_  
Signature of Patient or legal Representative

\_\_\_\_\_  
Date

If Legal Representative, Indicate relationship to patient: \_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If not signed by the patient, please indicate who signed:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

### Confidential Contact Information

- If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding test results with detailed information?  Yes or  No
- Best number to contact you with? \_\_\_\_\_  home  cell  work  
\_\_\_\_\_  home  cell  work
- What is the best time of the day to reach you? \_\_\_\_\_
- OK to fax to: \_\_\_\_\_
- Name and number of emergency contact person:

Name: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relation to patient: \_\_\_\_\_

PACIFIC E.N.T. MEDICAL GROUP  
CYNTHIA DAVIS, M.D., F.A.C.S.

CONTACT OFFICE  
FOR ANY QUESTIONS:  
(858)755-9343

# FINANCIAL POLICY

Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost for services you receive from Cynthia R. Davis, M.D. If our office has a contract with your insurance company, we will bill your insurance for you. It is the responsibility of the patient to know whether prior authorization or a second opinion is required by their insurance company prior to any office visit, surgery, or hospitalization. This requirement may affect your benefits and amounts paid by your insurance. Please inform this office if such authorization is required before services are rendered.

It is your responsibility to notify us if your insurance type, primary physician, primary medical group, or any other changes have occurred that could affect your insurance coverage for services about to be provided. If we are not informed prior to rendering services, you will be responsible for the cost of the services.

We accept assignment for all Medicare patients; co-payments and deductibles are due and payable at each visit. We regret that a charge of \$6.00 must be added when a bill is mailed for any late payments or co-pays due.

## DISABILITY FORMS

Because disability and other related forms have become more extensive and therefore more time consuming to fill out, there is now a \$15.00 charge for completing them. This is not covered by insurance and is therefore the patient's responsibility.

## MISSED APPOINTMENTS

Your appointment time is reserved for you. If you are unable to keep your appointment, we request that you notify us at least 6 working hours beforehand. There is a \$25 charge for appointments not canceled in advance.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PACIFIC E.N.T. MEDICAL GROUP  
CYNTHIA DAVIS, M.D., F.A.C.S.

CONTACT OFFICE  
FOR ANY QUESTIONS:  
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# **A MESSAGE TO PATIENTS ABOUT ARBITRATION**

When you come to the office you will be asked to sign an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Pacific ENT Medical Group, Inc.  
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Solana Beach, CA 92075  
(858) 755-9343  
Fax (858) 792-1790