Pacific ENT Medical Group, Inc.
6010 Hidden Valley Road, Suite 210
Carlsbad, CA 92011
(858) 755-9343

Last Name	First Name	MI	Birth Date	Todays Date
Address		City	State	Zip Code
Home Phone / Work Phone / Cell Phone		Sex	Marital Status	e-mail
Employers Name	Employers Address		Referring/Primary MD	Occupation
Emergency Contact	Relationship to Patient		Emergency Contact Phone	

Chose this clinic because/referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐Hospital
☐ Family ☐ Friend ☐Close to home/work ☐ Yellow Pages ☐ Other ☐ Website

Ethnic Classification–Check One: ☐**Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Declined** ☐**Unknown**

Race-Check One: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**
☐**Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Declined** ☐ **Unknown**

Language- Please Print Preferred Language:

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Guarantor's Last Name	Guarantor's First Name	MI	Relationship to Patient	
Guarantor's Address	City	State	Zip Code	
Guarantor's Home Phone	Guarantor's Cell Phone	Social Security #	Birth Date	Gender
Guarantor's Employers Name	Guarantor's Employer's Phone & Address			

PRIMARY INSURANCE

Insurance Name		Claims Address	
City, State, Zip	Insurance Phone Number		
Employer Group Insurance? ☐ Yes ☐ No Employer Name			
Subscribers Name	Gender		
Subscribers ID	Group No.		
Subscribers Birth Date	Effective Date		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

SECONDARY INSURANCE

Insurance Name		Claims Address	
City, State, Zip	Insurance Phone Number		
Employer Group Insurance? ☐ Yes ☐ No Employer Name			
Subscribers Name	Gender		
Subscribers ID	Group No.		
Subscribers Birth Date	Effective Date		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

I authorize the release of any medical information necessary to process medical insurance claims for services rendered.

SIGNED_____**DATE**__/__/__

I authorize and request medical insurance benefits to be paid directly to Pacific ENT Medical Group.

SIGNED_____**DATE**__/__/__

PACIFIC ENT MEDICAL GROUP
MEDICAL HISTORY RECORD
CYNTHIA R. DAVIS, M.D., F.A.C.S./ MOSES D. SALGADO, M.D./
HERNAN GOLDSZTEIN, M.D.

Date:_____ Referring Doctor:_____

Name:_____ Birthdate:_____Age:_____
Last First MI,Suffix 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	_____ppd 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 _____

Review of Systems

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

	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	_____

_____ _____

Patient Signature Date

(For internal use)

I have reviewed and confirmed the above with the patient_____

Pacific ENT Medical Group, Inc.

Consent for Diagnostic Tests/Procedures that may be Necessary to Fully Diagnose and Treat Your Condition

Patient Name:_____DOB:_____

Pacific ENT Medical Group physicians are pleased you have chosen them to assist in your care. Our physicians feel that a patient presenting to our office with sinus, allergy, throat, hearing or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures, which your physicians may feel is medically necessary. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. Insurance companies may consider the nasal endoscopy and laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or co-insurance. The following lists are the test/procedures that our physicians feel is medically necessary to perform:

- Ear wax Removal
- Control of Nosebleed
- Nasal Endoscopy
- Sinus cleaning ("debridement") after sinus surgery
- Laryngoscopy
- Video Laryngostroboscopy
- Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- Minor Surgical procedures and/or biopsies
- Ultrasound examination or guided biopsy
- Tympanogram
- Removal of foreign body from ear or nose

Please note that we collect all co-insurance and unmet deductibles at the time of the visit. Please sign below to acknowledge that you have read the above and understand your financial liability.

Signature:_____Date:_____

Pacific ENT Medical Group, Inc
Financial Policies

Name:_____
Date of Birth:_____

Pacific ENT Medical Group appreciates your confidence in choosing us to provide for your health care needs. Services rendered will be your financial responsibility you will assume an obligation to ensure payment in full of our fees. We would like to share our financial policies with you since a clear understanding of our financial policies is an important component of our professional relationship.

Methods of Payment

We will bill your insurance as a courtesy to you with a copy of your current insurance card, which must be presented at each visit. If you do not have your insurance card, payment is due at the time of service. For your convenience, we accept cash, check, and credit cards. Please note that there is a $25 charge for checks returned by the bank for insufficient funds.

Participation with Insurance and Medicare

Pacific ENT Medical Group participates with Medicare, as well as many PPO plans and one HMO plan, which means that we accept assignment of benefits. We do not participate in Medi-Cal (Medicaid). If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. If we do not have a contract with your insurance company, you are responsible for payment in full and consider to be Self-Pay. Payment is due at the time of service; we will supply you with a superbill to submit to your insurance company for direct reimbursement.

Medicare: As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance with a company with whom we are contracted, we will bill your secondary insurance for you. Any remaining balance will be billed to you.

PPO Plans: As a component of our contracts, we collect co-payments for every visit. If you have not met your deductable, we collect a deposit toward your services. You will receive a statement for the remaining balance after your insurance plan processes your claim.

HMO Plans: If you are insured through an HMO (Scripps Coastal or Affiliates), a referral is required from your primary care physician. If we do not receive a referral, we will require payment at the time of service. Our Contracted Payers: Aetna, Blue Cross, Blue Shield, Humana, Cigna, Great West, Medicare, United Healthcare, Tricare, First Health, PHCS.

Self Pay

We offer a 10% discount. All fees are due at the time of service.

No Show Fees

Please note that we may find it necessary to charge a No show fee of $25 if you cancel within 24 hours of your appointed time. We appreciate your calling so that your appointment time can be opened up to someone else in need.

Our Fees

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates. Co-payments, co-insurance, and deductibles, or unpaid balances are due at the time of serve.

Fees for Completion of Forms

There is a minimum charge of $35 to complete forms such as disability or FMLA forms.

I have read the Financial Policies of Pacific ENT Medical Group, Inc. I understand that it is my responsibility to provide current insurance information at each visit, as required by my insurance provided.

_____ _____

Signature of Patient or Guardian Date

Effective 12/1/2018