ENT
Group of Los Angeles

Ali R. Namazie, M.D., F.A.C.S.

PATIENT REGISTRATION FORM

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. Gender: ☐ Female ☐ Male ☐Transgender

Patient's Name (Last) _____ (First) _____ (MI) ___

Address_____Apt.No_____

City_____State_____Zip Code_____

Date of Birth_____ Social Security #: _____-_____-_____

Primary Care Physician:_____Phone #_____

Who referred you (if other than your PCP)?: _____

Telephone numbers (with area code please):

Home _____Can we leave a detailed message if needed?☐N ☐Y Initials_____

Mobile_____Can we leave a detailed message if needed? ☐N ☐Y Initials_____

Email address:_____

Employer _____ Phone no._____

Emergency Contact Name_____Phone No_____

Relationship to Patient_____

RESPONSIBLE PARTY INFORMATION (Parents or Guardian if pt. is a minor or incapacitated adult)

Responsible Party Name (Last) _____ (First) _____

Date of Birth_____ Social Security Number_____Relationship to Patient _____

ADDITIONAL INFORMATION (Collected in compliance with the Office of Management and Budget (OMB) to identify and eliminate healthcare access disparities)

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ White ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Primary Language (If other than English) _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge,

Patient (or Responsible Party) Signature_____Date_____

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NAME: _____ DATE: _____

REASON FOR VISIT: _____ DURATION OF PROBLEM: _____

MEDICATIONS (WITH STRENGTH AND DOSAGE)	
1	6
2	7
3	8
4	9
5	10

MEDICAL PROBLEMS – PAST & PRESENT (I.E. HIGH BLOOD PRESSURE, DIABETES, MIGRAINE, ETC.)	

ALLERGIES			
DRUG/FOOD	REACTION	DRUG/FOOD	REACTION

FAMILY HISTORY		
RELATIVE	ALIVE/DECEASED	MEDICAL PROBLEM (I.E. CANCER, GENETIC DISEASE, ETC.)
MOTHER		
FATHER		
OTHER		

Pharmac, Name: _____

Address: _____ City, _____

Phone #: _____

Previous Surgeries or Hospitalizations (including dates)

Do you drink alcoholic beverages? Yes No Amount _____

Do you use tobacco? Yes No Amount _____

Are you pregnant or nursing? Yes No N/A

Medical/Surgical History (check all that apply)

- ☐ Weight loss of 20 lbs. or more (last 6 mos.)
- ☐ Fever/Chills
- ☐ Headache
- ☐ Itching
- ☐ Cough
- ☐ Rash
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Frequent nosebleeds
- ☐ Difficulty swallowing
- ☐ Change in voice
- ☐ Throat pain
- ☐ Excessive sweating or Cold intolerance
- ☐ Frequent Urination
- ☐ Thyroid disease
- ☐ Weakness
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Irregular heartbeat
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Hepatitis
- ☐ Recent vomiting
- ☐ Swollen joints
- ☐ Muscle aches/cramps
- ☐ Eczema
- ☐ Blistering of skin
- ☐ History of keloids
- ☐ Photosensitivity
- ☐ Seizures
- ☐ Loss of vision

Other medical problems, please list: _____

Has anyone in your family had a problem with anesthesia? Yes No

If yes, please describe: _____

Do you, or any blood relatives, have a bleeding problem with surgery or cuts? Yes No

Do you take aspirin, ibuprofen, herbal medications, or similar blood thinners? Yes No

Is there any other information you think we should know?

_____

_____

ADVANCE NOTICE OF NON-COVERED SERVICES

Physician Notice

I am being advised by this letter that my insurance will only pay for services that it determines to be "medically necessary" and that are covered benefits. If my insurance company determines that a particular service, although it would be otherwise covered, is not medically necessary or a covered benefit, they will deny payment for that service. If something is not covered, I understand that I will be billed for payment on those services.

Beneficiary Agreement

I have been notified by my physician that he/she believes that the insurance carrier is likely to reimburse for medically necessary services; however, if the insurance company denies payment, I agree to be personally and fully responsible for the payment.

Waiver Form

I acknowledge that if my insurance does not show me eligible for coverage with the doctor I am seeing today, I will be responsible for paying for my medical services "in full".

Printed Name	Signature	Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ENT Group of Los Angeles for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ENT Group of Los Angeles may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ENT Group of Los Angeles is not required to agree to the restrictions that I may request. However, if ENT Group of Los Angeles agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing, at any time, except to the extent that ENT Group of Los Angeles has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ENT Group of Los Angeles Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices will be provided to me on request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations by ENT Group of Los Angeles. The Notice of Privacy Practices for ENT Group of Los Angeles practice is provided in a blue binder located in the waiting area. This Notice of Privacy Practices also describes my rights and ENT Group of Los Angeles's duties with respect to my protected health information.

ENT Group of Los Angeles reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by fax, or asking for one at the time of my next appointment.

Name of Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____