Westside Head and Neck

3831 Hughes Ave Suite 704, Culver City CA 90232
1301 20th St Suite 510, Santa Monica CA 90404
Tel: (310)204-4111
Fax (310)204-4474

Michelle Putnam, MD Amanda Salvado, MD Behrad Aynehchi, MD
Dorothy Wang, MD Julianna Pesce, MD

Patient Name: _____ Date of Birth: ____/____/____
Last First MI

Social Security Number: _____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: _____
(Street) (City/State/Zip)

Home Phone: (____) _____ Cell Phone: (____) _____ Other Phone: (____) _____

E-mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? (Appointment, test results and bills) Yes No

Employer Name: _____ Employer Phone Number: (____) _____

Employer Address: _____
(Street) (City/State/Zip)

Primary Care Physician: _____ Phone: (____) _____
(Name)

Whom shall we thank for referring you? _____

Responsible Party (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ Date of Birth: ____/____/____

Relationship to Patient: (please check): ( ) spouse ( ) parent ( ) legal guardian

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____
(Street) (City/Street)

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Other Phone: (____) _____

Primary Insurance Information

Insurance Company Name: _____

Address: _____ Phone: (____) _____
(Street) (City/State/Zip)

I.D. Number: _____ Group Number: _____ Effective Date: _____

Policy Holder: _____ Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: ____/____/____ Sex: M / F Relationship to Patient: (please check): ( ) spouse ( ) parent

Secondary Insurance Information

Insurance Company Name: _____

Address: _____ Phone: (____) _____
(Street) (City/State/Zip)

I.D. Number: _____ Group Number: _____ Effective Date: _____

Policy Holder: _____ Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: ____/____/____ Sex: M / F Relationship to Patient: (please check): ( ) spouse ( ) parent

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? ***YES*** ***NO***
IF YES, PLEASE NOTIFY THE FRONT DESK

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Westside Head and Neck. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Westside Head and Neck is not a Medi-Cal Provider

Authorizations: May we send your physician a report of our findings? 9 Yes 9 No
Do you authorize the discussion of your case or diagnosis with your immediate family? 9 Yes 9 No

Signature: _____ Date: _____

Westside Head And Neck

In an effort to comply with requirements mandated by the Federal Government, please provide us with the following information:

RACE:

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Indian
_____ Multiracial
_____ Pacific Islander
_____ Other Race
_____ Unknown/ Decline to Answer
_____ White

PREFFERED LANGUAGE:

_____ Arabic
_____ Chinese
_____ English
_____ Farsi
_____ French
_____ Korean
_____ Russian
_____ Spanish
_____ Other _____

ETHNICITY:

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Unknown/Decline to Answer

Signature of Patient/Guardian **Today's Date**

MICHELLE A. PUTNAM M.D.
DOROTHY WANG M.D.
JULIANNA PESCE M.D.
AMANDA R. SALVADO M.D
BEHRAD B. AYNEHCHI M.D.

OTORHINOLARYNGOLOGY
FACIAL COSMETIC SURGERY
HEAD AND NECK SURGERY
LIPOSUCTION SURGERY

3831 Hughes Ave., Suite 704, Culver City, CA 90232 • Tel: (310)204-4111 • Fax: (310)204-4474 • Email:mputnam@westsidehn.com

Name: _____ **Date of Birth:** _____

Please Summarize the Reason For Your Visit: _____

_____

Please Check Any of the Following That Apply to You:

Ear Problems
- ❑ Hearing Problems
- ❑ Ear Pain or Pressure
- ❑ Ear Drainage
- ❑ Ear Ringing / Noise
- ❑ Exposure to Loud Noises
- ❑ Hearing Aids
- ❑ Dizziness / Loss of Balance
- ❑ Past i.v. "…mycin" Antibiotics

Throat / Nasal Problems
- ❑ Swallowing Problems
- ❑ Frequent Sore Throat
- ❑ Prolonged Hoarseness
- ❑ Nasal Obstruction / Bleeding
- ❑ Sinus Infections
- ❑ Allergy Problems
- ❑ Facial Pain / Headaches

Other Problems
- ❑ Lumps in the Neck
- ❑ Frequent Colds
- ❑ Heartburn / Indigestion
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Cough
- ❑ Wheezing
- ❑ Bleeding Problems

❑ Past Ear, Nose and Throat Operations: _____

Please Check If You Have Any of the Following Medical Problems:
- ❑ High Blood Pressure
- ❑ Previous Heart Attack
- ❑ History of Chest Pain
- ❑ History of Heart Disease
- ❑ Ulcers
- ❑ Family History of Bleeding Problems
- ❑ Asthma / Emphysema
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Previous Cancer

List Any Other Medical Problems, Previous Hospitalizations or Previous Surgeries:

_____

_____

Are You Allergic to Any Medications? ☐ **NO** ☐ **YES: Which Ones:** _____

How Many Drinks of Alcohol Do you Have Per Day:? _____ **Or Per Week?** _____

Do You Now Smoke?: ☐ **NO** ☐ **YES: How Many Packs per Day?:** ____ **For How Many Years?:** ____

Did You Used to Smoke?: ☐ **NO** ☐ **YES: How Many Packs per Day?:** ____ **When Did You Quit?:** ____

Do You Take ANY Medications: ☐ **NO** ☐ **YES:**

Please List All Medications You Are Currently Taking (Including Over-the-Counter and Homeopathic Medications):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

❑ Check Here If You Take More Than 6 Medications and Continue List On Reverse Side of This Page.

I HEREBY CONSENT TO ANY EXAMINATION, LABORATORY TESTS, ANESTHESIA, MEDICAL OR SURGICAL TREATMENT, OR CLINICAL SERVICES DEEMED MEDICALLY NECESSARY BY MY PHYSICIAN.

Patient Signature: _____ **Date:** _____

Do you CURRENTLY have ?(IF YES, CHECK APPORIATE BOXES)

GENERAL
{ } Fatigue
{ } Fever
{ } Weight Gain>10 pounds
{ } Weight Gain<10 pounds

SKIN
{ } Nail Change
{ } New Lesions
{ } Rash
{ } Skin Color Change

HEENT
{ } Double Vision
{ } Eye Pain
{ } Eye Redness
{ } Decrease Hearing
{ } Earache
{ } Ear Ringing
{ } Nose Bleeds
{ } Dry Mouth
{ } Hoarseness
{ } Oral Ulcers
{ } Sore Throat

NECK
{ } Neck Pain
{ } Swollen Glands

RESPIRATORY
{ } Chronic Cough
{ } Decrease Exercise Tolerance
{ } Difficulty Breathing
{ } Coughing up Blood
{ } Sputum Production
{ } Wheezing

BREAST
{ } Breast Mass
{ } Breast Pain
{ } Nipple Discharge
{ } Skin Changes

CARDIOVASCULAR
{ } Chest Pain
{ } Leg Pains with walking
{ } Leg Swelling
{ } Night Awakening due to trouble breathing
{ } Palpitations
{ } Shortness of breath

GASTROINTESTINAL
{ } Abdominal Pain
{ } Changes in Bowel Habits
{ } Constipation
{ } Diarrhea
{ } Nausea/Vomiting
{ } Rectal Bleeding { } Trouble Swallowing

GENITOURINARY
{ } Vaginal Discharge
{ } Menstrual Irregularities
{ } Difficulty Starting/Stopping urinary Stream
{ } Painful Urination
{ } Change In Urinary Stream
{ } Increase Frequency
{ } Blood in Urine
{ } Loss of Bladder Control
{ } Nightmare Urination
{ } Urinary Retention
{ } Urethral Discharge
{ } Impotence
{ } Penile Lesions
{ } Testicular Mass
{ } Testicular Pain

MUSCULOSKELETAL
{ } Decrease Range of Motion
{ } Joint Pain
{ } Joint Redness
{ } Joint Swelling
{ } Joint Stiffness
{ } Muscle Wasting
{ } Muscle Weakness
{ } Muscle Aches/Pains

NEUROLOGICAL
{ } Loss of Bowel Control
{ } Dizziness/Vertigo
{ } Headaches
{ } Numbness/Tingling
{ } Passing Out
{ } Seizures
{ } Tremor

PSYCHIATRIC
{ } Anxiety
{ } Change in Sleep Pattern
{ } Depression
{ } Hallucinations
{ } Suicidal Thoughts

ENDOCRINE
{ } Appetite Change
{ } Cold Intolerance
{ } Increase Thirst
{ } Increase Urination
{ } Hair Changes
{ } Sexual Dysfunction

HEMATOLOGY
{ } Easy Bruising
{ } Enlarged Lymph Nodes
{ } Prolonged Bleeding

Westside Head and Neck Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Westside Head and Neck, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involved in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your Insurance Company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service, in a confidential manner. We have a written contract with each business associate that requires them to protect your privacy as well.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your requests to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (310) 204-4111.

As required by a new federal law, this notice goes into effect as of April 14, 2003. **Acknowledgement:** I have received a copy of the Westside Head and Neck, Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____
If signing as a parent or guardian, please note the name of the patient: _____

Westside Head and Neck

Michelle Putnam• Amanda Salvado• Dorothy Wang• Behrad Aynehchi• Julianna Pesce

FINANCIAL DISCLOSURE FOR OFFICE VISIT/PROCEDURES

The Westside Head and Neck physicians are pleased you have chosen them to assist in your care. The physicians feel that patients presenting to our offices with sinus, allergy, throat, hearing or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests or procedures. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. The following is a list of the tests/procedures that may be performed or ordered. These procedures are often considered surgical procedures by insurance companies and may be applied to your deductible or coinsurance. These are usually but not always fully covered by your insurance plan:

Audiogram (Hearing Test) /Balance Testing
CAT Scan
Laryngoscopy or Flexible Endoscopy (Nasopharyngoscopy)
Nasal Endoscopy
Sinus Cleaning ("debridement") after sinus surgery
Video Laryngostroboscopy
Voice Evaluation (sometimes termed "therapy" by insurance)
Voice Therapy
Minor Surgical Procedures and/or Biopsies
Cerumen Removal

• The patient's insurance policy is a contract between the patient and his or her insurance company. However, **all charges are the patient's responsibility regardless of the insurance coverage** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, Westside Head and Neck bills the patients' insurance and makes every effort to ensure that claims are promptly and correctly processed.

• Please be advised that it is your responsibility to verify your insurance benefits to ensure that you are in network with Westside Head and Neck. Therefore you will be responsible for **ALL** balances not covered by your insurance.

• We may charge a **NO SHOW** fee of $75 for appointments cancelled without 24 hours advance notice.

I have read and agree to the above policy.

_____	_____	_____
Name	**Signature**	**Date**