Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, DNP, NP-C
Doctor of Nursing

Patient Information

Date: _____ Patient: _____ ( ) Male ( ) Female

Date of Birth: _____ Marital Status: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone #: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Referred by/Primary care doctor:_____

Responsible Party: _____ Responsible Party's Date of Birth: __/__/____

Relationship to Patient: _____

Primary Insurance: _____

Policy #/Subscriber ID#: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance: _____

Policy#/Subscriber ID#:_____Group:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Pharmacy name and cross streets_____

Assignment and Release:

I hereby assign my insurance benefits to be paid directly to Estrella Ear, Nose & Throat. I understand that I am financially responsible for any non-covered service and co-insurance amounts. I also authorize Estrella Ear, Nose & Throat to release any information required to process my insurance claims

Signed: _____ Date: _____

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Please complete the following:

You have my consent to leave messages with family members or significant others and/or on my answering machine. YES _____ NO _____

You have my consent to discuss my medical treatment/condition with the following:

Name	Relationship
Name	Relationship
Name	Relationship

Assignment & Release

I also authorize the release of any information required to process insurance claims, including any information relating to alcohol, drug abuse, and/or AIDS. I authorize release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and others involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at any time.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of Estrella Ear, Nose and Throat may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure or referral and that I have the option to decline such treatment or seek further information.

_____ _____
Patient Signature or Signature of Parent/Guardian Date

_____ _____
Patient Name (if patient is a minor) Relationship to Patient

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Estrella Ear, Nose & Throat Financial Policy

Thank you for choosing Estrella Ear, Nose & Throat. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

1. ____ I understand that if I do not have my insurance card, referral and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments. I further understand that for a deductible of $250 or more, I will be asked to fill out a credit card authorization form in order to process payment once your claim has been posted to your insurance company and the office visit has been applied to your deductible.
2. ____ I understand that if my account is not paid in full, my account will be turned over to a third-party collections company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current.
3. ____ I understand that if I am unable to make a scheduled appointment I need to contact Estrella Ear, Nose & Throat at least ***24 hours*** before my scheduled appointment time. ***An automated reminder call will be made on your behalf and it is necessary that you provide us with a primary phone number from which you check your messages regularly.*** Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent appointments from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENT NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE. If a patient misses 2 visits, Estrella Ear, Nose & Throat reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient notifying you of such a change.
4. ____ **It is my responsibility to provide correct insurance information and notify Estrella Ear, Nose & Throat if there is a change in my insurance coverage, residence, or phone number. It is also my responsibility to provide my insurance company with any information that may be requested by them in order to process a claim for services.** If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner, I understand that I will be financially responsible for any and all treatment(s) received. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**
5. ____ I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____ _____

Printed Name of Patient Signature of Patient/Responsible Person Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have been offered a copy of
(Name of Patient)

ESTRELLA EAR, NOSE, AND THROAT **"Notice of Privacy Practices".** This notice describes how ESTRELLA EAR, NOSE, AND THROAT may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to patient)

HIPAA-ACK2

estrella
EAR, NOSE AND THROAT, P.C.

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Patient Name: _____ **DOB:**_____ **Date:**_____

LATEX ALLERGY? ☐ Yes ☐ No

If yes, what type of reaction? _____

ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No

If yes, please list.

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

FAMILY HISTORY:

ADD/ADHD	☐ Yes	Hearing deficiency	☐ Yes
Alcoholism	☐ Yes	Hyperlipidemia	☐ Yes
Allergies	☐ Yes	Hypertension	☐ Yes
Alzheimer's Disease	☐ Yes	Mental illness	☐ Yes
Asthma	☐ Yes	Migraines	☐ Yes
Blood disease	☐ Yes	Obesity	☐ Yes
CAD (Coronary Artery Disease)	☐ Yes	Osteoarthritis	☐ Yes
Cancer Type: _____	☐ Yes	Osteoporosis	☐ Yes
CVA (Stroke)	☐ Yes	PVD	☐ Yes
Depression	☐ Yes	Renal disease	☐ Yes
Developmental delay	☐ Yes	Seizure disorder	☐ Yes
Diabetes	☐ Yes	Other: _____	

SOCIAL HISTORY:

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**

Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** _____ **Amount per day?** _____

SURGICAL HISTORY:

List *ANY and ALL* surgeries/procedures you have had done.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

***MEDICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Past Medical History**

		Year Diagnosed
Cardiovascular:		
Coronary Artery Disease	☐ **Yes**	_____
Elevated cholesterol (hyperlipidemia)	☐ **Yes**	_____
High Blood Pressure (hypertension)	☐ **Yes**	_____
Other	☐ **Yes**	_____
Gastrointestinal:		
Hepatitis	☐ **Yes**	_____
Hernia	☐ **Yes**	_____
Gastroesophageal Reflux	☐ **Yes**	_____
Other	☐ **Yes**	_____
Genitourinary:		
Prostate enlargement (Prostatitis)	☐ **Yes**	_____
Kidney Stones (Nephrolithiasis)	☐ **Yes**	_____
Acute Renal Failure	☐ **Yes**	_____
Other	☐ **Yes**	_____
Infectious Disease:		
Mononucleosis	☐ **Yes**	_____
STD Type: _____	☐ **Yes**	_____
Other	☐ **Yes**	_____
Metabolic/endocrine:		
Diabetes	☐ **Yes**	_____
Thyroid deficiency (hypothyroidism)	☐ **Yes**	_____
Thyroid excess (hyperthyroidism)	☐ **Yes**	_____
Thyroid mass	☐ **Yes**	_____
Other	☐ **Yes**	_____
Neoplastic:		
Cancer Type: _____	☐ **Yes**	_____
Treatment	☐ **Yes**	_____
Treatment Type:	Chemo Radiation Surgery	
Other	☐ **Yes**	_____
Neurologic:		
Migraine	☐ **Yes**	_____
CVA (stroke)	☐ **Yes**	_____
Seizures	☐ **Yes**	_____
Alzheimer's Disease	☐ **Yes**	_____
Other	☐ **Yes**	_____
Obstetric:		
Pregnancy(s) #_____	☐ **Yes**	_____

Ear / Nose / Throat: (ENT)		
Cataracts	☐ **Yes**	_____
Glaucoma	☐ **Yes**	_____
Chronic ear infections (otitis media)	☐ **Yes**	_____
Hearing loss	☐ **Yes**	_____
Sinus problems (chronic sinusitis)	☐ **Yes**	_____
Nasal polyps	☐ **Yes**	_____
Nasal allergies	☐ **Yes**	_____
Recurrent tonsillitis	☐ **Yes**	_____
Tinnitus	☐ **Yes**	_____
Vertigo	☐ **Yes**	_____
Other	☐ **Yes**	_____
Hematologic :		
Anemia	☐ **Yes**	_____
Other	☐ **Yes**	_____
Immunologic:		
Allergies Type: _____	☐ **Yes**	_____
Food Allergies Type: _____	☐ **Yes**	_____
HIV / AIDS	☐ **Yes**	_____
Other	☐ **Yes**	_____
Psychiatric:		
Anxiety	☐ **Yes**	_____
Depression	☐ **Yes**	_____
Other	☐ **Yes**	_____
Pulmonary:		
Asthma	☐ **Yes**	_____
COPD/Emphysema	☐ **Yes**	_____
Sleep Apnea	☐ **Yes**	_____
CPAP	☐ **Yes**	_____
Tuberculosis	☐ **Yes**	_____
Other	☐ **Yes**	_____
Miscellaneous:		
Anesthesia Reaction	☐ **Yes**	_____
Other	☐ **Yes**	_____
Miscellaneous PEDIATRIC:		
Complications during Pregnancy	☐ **Yes**	_____
Complications during Delivery	☐ **Yes**	_____
Failed newborn hearing screening	☐ **Yes**	_____
NICU stay >48hrs:_____	☐ **Yes**	_____
Preterm birth	☐ **Yes**	_____
Other	☐ **Yes**	_____

REVIEW OF SYSTEMS: Check any of the following problems you have recently had:

General health problems
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐weight gain ☐sleeping problems

Eye problems
☐blurred vision ☐double vision ☐itching ☐eye pain ☐redness ☐swelling

Ear problems
☐hearing loss ☐ear pain ☐dizziness ☐ringing/noise in ears ☐ears feel pressured ☐discharge/drainage from ears
☐ear infections ☐itchy ☐noise exposure

Nose & Sinus problems
☐nose bleeds ☐chronic congestion ☐nose/sinus problems ☐runny nose ☐sinus pressure

Mouth & Throat problems
☐sore throat ☐snoring ☐dry mouth ☐sores in mouth ☐ulcers ☐difficulty swallowing ☐post nasal drip
☐hoarseness ☐ mouth breathing

Brain or Nervous system problems
☐fainting ☐frequent headaches ☐seizures ☐numbness ☐migraines ☐loss of consciousness
☐facial pain ☐weakness

Heart or circulation problems
☐chest pain ☐heart murmur ☐irregular heart beat ☐light-headed upon standing ☐swelling of ankles ☐blacking out

Lung or respiratory problems
☐wheezing ☐shortness of breath ☐ cough ☐ sleep apnea

Stomach problems
☐vomiting ☐heartburn ☐painful swallowing ☐no appetite ☐increased appetite ☐abdominal pain
☐diarrhea ☐nausea

Blood or Lymph node problems
☐swollen glands ☐bruises easily ☐bleeds excessively after injury ☐enlarged lymph nodes

Muscle problems
☐muscle aches ☐joint pain ☐leg cramping

Skin
☐rash ☐itchy ☐dry skin ☐growth/lesions ☐swelling ☐urticaria / hives

Glands & Hormone problems
☐increased thirst ☐increased appetite ☐intolerance to heat ☐intolerance to cold ☐neck enlargement

Allergy problems
☐frequent sneezing ☐runny nose
☐food intolerances ☐insect bites ☐other _____

What is the reason you are here today? _____

_____

_____

Responsible Party Signature: _____ **Date:** _____