

## BEACH CITIES ENTS MEDICAL HISTORY

In order for us to obtain a complete medical history, it is important to fill out this form as completely as possible. **Please fill out every item.** This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Sex: Male Female Ethnicity: Hispanic or Not Date of Birth: \_\_\_\_\_

Race: *Please circle your choice:* Caucasian African American Declined  
 Asian Hawaiian/Pacific Islander  
 Hispanic/Latino American Indian

Please provide us your email for an alternative means to contact you: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Name of Primary or Referring Physician: \_\_\_\_\_

HAVE YOU EVER BEEN A PATIENT AT BEACH CITIES ENTS BEFORE? Yes No When? \_\_\_\_\_

WHAT IS YOUR REASON FOR TODAY'S VISIT: \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING? Fatigue Yes No Snoring Yes No  
*Circle Yes or No.* Hearing Loss Yes No Cough Yes No  
 Nasal Congestion Yes No Facial Pain Yes No

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_ Yes \_\_\_ No.

If yes, please list below:

Name of Medication	Type of Reaction

Pharmacy Preference (include location): \_\_\_\_\_

Do you consent for us to obtain your medications from your pharmacy? Yes No

**MEDICATIONS.** Please provide us a written list of your medications or write ANY AND ALL MEDICATIONS YOU ARE CURRENTLY TAKING below including over the counter medications.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL History:** *Check if Yes.*

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Inflammatory Bowel Disease (IBS) | <input type="checkbox"/> Rheumatoid arthritis        | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Atrial fibrillation (A fib) | <input type="checkbox"/> Back Problems   |
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Breast Cancer                    | <input type="checkbox"/> COPD (Emphysema)            | <input type="checkbox"/> Cancer _____    |
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Heart Failure (CHF)              | <input type="checkbox"/> Coronary artery disease     | <input type="checkbox"/> Dementia        |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Dermatitis                       | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Eczema          |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Reflux (GERD)                    | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Gout            |
| <input type="checkbox"/> HIV +             | <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Hypertension (High BP)      | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Heart attacks     | <input type="checkbox"/> Degenerative Arthritis           | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Kidney stones     | <input type="checkbox"/> Stroke                           | <input type="checkbox"/> Tuberculosis (Tb)           | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Ulcers            |   |  |  |

Besides those checked above, please list any other medical problems or diagnoses you have:

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Have you ever smoked? Yes No What years did you smoke? \_\_\_\_\_

Do you drink alcohol? Yes No How much do you drink? \_\_\_\_\_ How often? \_\_\_\_\_

Have you used cocaine? Yes No How many years? \_\_\_\_\_

**PAST SURGERIES:** *Check if Yes.*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy          | <input type="checkbox"/> Breast Reduction  | <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Cataract surgery            |
| <input type="checkbox"/> Cesarean Section      | <input type="checkbox"/> Gallbladder       | <input type="checkbox"/> CABG – Coronary bypass | <input type="checkbox"/> Ectopic Pregnancy           |
| <input type="checkbox"/> Fracture              | <input type="checkbox"/> Gastric Banding   | <input type="checkbox"/> Heart valve surgery    | <input type="checkbox"/> Hernia (abdominal)          |
| <input type="checkbox"/> Hip Fracture          | <input type="checkbox"/> Hip surgery       | <input type="checkbox"/> Hysterectomy           | <input type="checkbox"/> Knee Arthroscopy            |
| <input type="checkbox"/> Knee surgery          | <input type="checkbox"/> Spine surgery     | <input type="checkbox"/> Lasik                  | <input type="checkbox"/> Mastectomy (Breast CA)      |
| <input type="checkbox"/> Myringotomy and tube  | <input type="checkbox"/> Nasal Septoplasty | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Coronary angioplasty/stents |
| <input type="checkbox"/> Other surgeries below | <input type="checkbox"/> Prostate biopsy   | <input type="checkbox"/> Shoulder Arthroscopy   | <input type="checkbox"/> Shoulder surgery            |
| <input type="checkbox"/> Thyroidectomy         | <input type="checkbox"/> Tonsillectomy     | <input type="checkbox"/> Prostatectomy          | <input type="checkbox"/> Tubal Ligation              |
| <input type="checkbox"/> Vasectomy             |  |   |  |

Besides those checked above, please list any surgeries you have had (including dates):

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**WHAT TESTS OR STUDIES HAVE BEEN DONE FOR THE PROBLEM TODAY?**

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**WHAT MEDICATIONS HAVE YOU TRIED OR BEEN GIVEN FOR THE PROBLEM TODAY?**

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**BEACH CITIES ENTS**  
EAR NOSE THROAT SURGEONS

**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

                    Last                      First                      Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**RECIPIENT FOR DELIVERY OF RECORDS:**

BEACH CITIES ENTS  
20911 Earl Street, Suite 340, Torrance, CA 90503  
FAX: 310-944-9295

Purpose: I understand that the specific purpose of this Authorization is \_\_\_\_\_

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

\_\_\_\_\_ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

\_\_\_\_\_ All of my health information described above except for the following:

\_\_\_\_\_ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.



# BEACH CITIES ENTS

## Adult and Pediatric Ear, Nose, Throat & Sinus

### OFFICE FINANCIAL AND PAYMENT POLICY (Updated 01/01/2025)

If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). **If you provide us with different insurance from the date of your visit and we are not contracted with your correct updated insurance, the patient is responsible for services rendered.** We are required to obtain your signature for permission to release information to your insurance carrier annually.

**NO SHOW POLICY:** We ask for a 2-business days notice if you must cancel or reschedule an appointment to allow more availability for patients who desire to be seen. There will be a **\$50 charge** for appointments made which you do not show or do not cancel with 2-business day notice.

*Please initial here:* \_\_\_\_\_

**SURGERY/IN OFFICE PROCEDURE POLICY:** If you schedule surgery/in office procedure and need to cancel or reschedule, we ask for 3 weeks notice prior to the surgery/procedure date in order to allow other patients access to the limited operating room time. If this adequate notice is not given, there will be a \$500 late cancellation/reschedule fee. Surgery or in office procedures that are scheduled less than a 3-week time frame, are held to the same policy standard.

*Please initial here:* \_\_\_\_\_

As a courtesy, we will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services in an appropriate time period. **It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements.** We will, however, assist you to ensure all plan requirements are met.

Payment for services, including **co-payment, co-insurance and deductible amounts, is due at the time services are rendered. We do not bill secondary insurance for co-pays. We expect copay payments for primary and secondary insurances at the time of visit.** Beach Cities ENTS accepts cash or all major credit cards (Visa, Mastercard, Discover, and AMEX). **We DO NOT accept personal checks.** Any non-covered services are your responsibility. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. There is a **\$25 charge for any forms** that require completion by our office.

**We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** If there is a dispute with your insurance company, you will receive a letter from our billing service asking for your help by your contacting your insurance company to assist with processing and payment of the services provided to you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to promptly contact our billing service at 888-902-0255 for assistance in the management of your account. Thank you. Your signature below constitutes acknowledgement and acceptance of this policy.

Signature: \_\_\_\_\_

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

Notice to Patients

“The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.”

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_