MINOR PATIENT INFORMATION

How did you hear about our practice?____

Patient Name: ____
First M.I. Last

Date of Birth: _____/_____/______ Age: ________ Sex: [] M [] F Race: _________ Ethnicity: _________

Mailing Address: ____

City ______________________________ State______________ Zip: __________________

Primary Phone (_____) ____________________ Secondary Phone: (_____) ____________________

Preferred Communication Method (circle all that apply) Call Text Email

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Minor living with: ☐ Both Parents ☐ Mother ☐ Father **Legal Guardian:** ☐ Parents ☐ Other (Please see below)

Father: Name: ________________________ Date of Birth: _____/_____/______SSN ____________

Phone: (____) ____________ Email: ________________________ Employer: ____________

Mother: Name: ________________________ Date of Birth: _____/_____/______ SSN ____________

Phone: (____) ____________ Email: ________________________ Employer: ____________

Legal Guardian if not Parent: Name: ______________________ Date of Birth: _____/_____/______

SSN __________________ Phone: (____) ____________ Email: ________________________

Primary Insurance ____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Mom ☐ Dad ☐ Other: ___________________________________
Name / DOB/ Employer

Secondary Insurance ____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Mom ☐ Dad ☐ Other: ___________________________________
Name / DOB/ Employer

Preferred Pharmacy: ____
Name Location

Referring Physician: ____________________ Primary Care Physician: ____________________

IMPORTANT:

Will anyone other than the parent/legal guardian bring the patient to an appointment? ☐ Yes ☐ No
If yes, please complete Advanced Consent form.

________________________________ ________________________

Signature of Parent or Legal Guardian **Date**

***** PLEASE TURN OVER, READ & SIGN*****

SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS

FINANCIAL POLICY

Thank you for choosing Spokane Valley Ear, Nose & Throat and Facial Plastics for your healthcare needs. The following information is being provided to assist you in understanding our financial policies. If you have any questions, always feel free to contact our billing office at (509) 928-6044 and we will be happy to help you.

ACCOUNT RESPONSIBILITY You are responsible for all charges incurred on your account. It is your responsibility to make sure that the information we have is current and accurate and to know what your insurance contract benefits will cover and pay.

INSURANCE BILLING If you have medical insurance, we will be happy to bill your insurance carrier(s) for you. **OFFICE VISITS AND PROCEDURES PERFORMED IN THE OFFICE ARE CONSIDERED SEPARATE BY MOST INSURANCE COMPANIES AND MAY GO TOWARD YOUR DEDUCTIBLE.** You will also need to check amounts of copays, deductibles and if referrals are required. If your insurance requires a referral, it is **your** responsibility to make sure that referral is in place prior to your appointment. **Insurance cards, DSHS Provider One cards and copays are always due at the time of service. If these are not presented, we may have to reschedule your appointment.** Any unpaid balance after insurance pays is the patient's responsibility.

SURGERY POLICY If you are having surgery and/or a procedure in the office or at a facility, as a courtesy we will check with your insurance for authorization needed and for **estimated** co-insurance/deductible amounts. Our billing department will notify you before surgery if we need to collect a co-ins/deductible amount prior to your surgery. If you are not able to pay the co-insurance/deductible estimate before surgery, we will be happy to reschedule your surgery to a more convenient time.

PAYMENT TERMS **Balances** ***are due in full within 30 days of receiving statement,*** unless arrangements have been made. All delinquent accounts will be turned over to our Collection Agency after 90 days. An interest charge of 1% will be added monthly to unpaid balances at 60 days.

NO INSURANCE If you have no insurance, payment in full is expected at time of service, unless arrangements have been made prior to your visit.

PAYMENT METHODS We accept cash, personal checks, Visa, Mastercard, American Express, and Discover.

NSF CHECKS A $35.00 service charge will be assessed on all NSF checks.

LAB CHARGES All blood work, cultures and biopsies will be charged by an independent lab.

INSURANCE & FMLA PAPERWORK Forms submitted to us for completion such as insurance forms or FMLA are subject to a $30.00 fee to cover administrative costs.

I have read and understand each of the above items.

PATIENT NAME: ______________________________

SIGNATURE: ______________________________ **DATE:** ______________ revised 01/30/15

SPOKANE VALLEY EAR, NOSE & THROAT (SVENT)
Notice of Privacy Practices

By signing this form, you acknowledge that you have been informed that Spokane Valley Ear, Nose & Throat and Facial Plastics (SVENT) provides information about how we may use and disclose your protected health information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Spokane Valley Ear, Nose & Throat and Facial Plastics may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

Please check all that apply:

Can we leave a message on your answering machine/voicemail? ☐ **Yes** ☐ **No**

Can we leave a message for you at your work number? ☐ **Yes** ☐ **No**

Can we discuss your medical condition with family or friends who call the office?

☐ **Yes** ☐ **No** If yes, whom may we speak to? ____________________________________

____

____

This section to be completed by Minors aged 13-18

For Minors Ages 13-18

I DO ☐ I DO NOT ☐ authorize my parent / guardian to view or access **ALL** my medical records, including any sensitive information. (Including reproductive care, sexually transmitted diseases, HIV/AIDS, drug and/or alcohol abuse and mental health)
This authorization will remain in effect until the age of 18 or until revoked by you.

Minor Signature if applicable ______________________________ Date ______________

Questions and/or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer, Karen Caudill at 509-340-8316.

Patient's Printed Name: ______________________ Patient's Date of Birth: ____________

Signature ______________________________ Date ______________
(Patient/Parent/Guardian) (Mo/Day/Yr)

Today's Date: ________________

Spokane Valley Ear, Nose & Throat and Facial Plastic Surgery **New Patient History Form**

Name: ______________________________ DOB:______________ Age: ______

Referring Physician: ____

Reason for Your Visit: ____

How Long Have You Had Symptoms? __________________________________

Past Medical History

Circle which of the following you have or had:	**Please Specify:**
Diabetes/ thyroid /endocrine problems	______________________
Heart / vascular problems	______________________
Lung problems/ asthma /pneumonia	______________________
Kidney or urinary problems	______________________
Liver problems or viral hepatitis	______________________
Bleeding or clotting problems	______________________
Cancer or any tumors	______________________
Neurologic/ brain problems /headaches	______________________
Depression/ anxiety /psychiatric	______________________
HIV or AIDS	______________________
Osteoarthritis or joint problems	______________________
Rheumatoid arthritis/ lupus /autoimmune	______________________
Hearing or vertigo disorders	______________________
Gastroesophageal reflux / esophageal	______________________
Speech or swallowing disorders	______________________
Sinus/ nasal /eye /facial problems	______________________
Skin disorders	______________________
Sleep Disorders/Apnea/CPAP	______________________

Past Surgical History List all surgeries you have had:

____

____

____

____

Family History

Indicate which of the following run in your family:

	Father	Mother	Sibling	Other	
Cancer or Benign tumors	☐	☐	☐	☐	____________
Hearing loss	☐	☐	☐	☐	____________
Allergies or Asthma	☐	☐	☐	☐	____________
Bleeding or clotting disorders	☐	☐	☐	☐	____________
Heart or lung problems	☐	☐	☐	☐	____________
Diabetes, thyroid, endocrine problems	☐	☐	☐	☐	____________
Lupus, Multiple Sclerosis, autoimmune	☐	☐	☐	☐	____________
Neurologic or genetic conditions	☐	☐	☐	☐	____________

Social History

Occupation / what you do for work: ____

Who do you live with? ____

Tobacco /smoking: ☐ never ☐ previous, when did you quit? __________ ☐ Yes, how Often? ________

Environmental in-home smoke exposure: ☐ Yes ☐ No

Alcohol consumption: ☐ daily ☐ 1-4 times /week ☐ less than 1 time /week ☐ never

Recreational drugs: ☐ heroin or opioids ☐ cocaine ☐ marijuana ☐ other __________

Medications: (Include dosage, frequency and list all herbal, over-the-counter, & topical treatments)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Drug Allergies: List drug and reaction: ☐ None known

____

____

____

SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS SYSTEM REVIEW

Please circle if *you* have *ever* had any of the following:

Constitutional Symptoms

Recent Headaches.............	No	Yes
Recent weight change.........	No	Yes
Recent Fever..................	No	Yes
Recent Fatigue................	No	Yes

Eyes

Eye disease or injury..........	No	Yes
Wear glasses/contacts.........	No	Yes
Blurred/double vision.........	No	Yes
Glaucoma.....................	No	Yes

Ears/Nose/Mouth/Throat

Hearing Loss/ringing.........	No	Yes
Earaches or drainage..........	No	Yes
Chronic sinus problems......	No	Yes
Nose bleeds..................	No	Yes
Mouth sores..................	No	Yes
Bleeding gums................	No	Yes
Bad breath or taste...........	No	Yes
Sore throat/voice change.....	No	Yes
Swollen glands in neck.......	No	Yes

Cardiovascular

Heart trouble/Disease.........	No	Yes
Chest pain....................	No	Yes
Palpitations..................	No	Yes
Shortness of breath...........	No	Yes
Swelling of feet/ankles.......	No	Yes
High blood pressure..........	No	Yes

Respiratory

Chronic/frequent cough......	No	Yes
Spitting up blood	No	Yes
Asthma.......................	No	Yes
Wheezing....................	No	Yes
Sleep Apnea..................	No	Yes

Gastrointestinal

Loss of appetite...............	No	Yes
Nausea/vomiting.............	No	Yes
Rectal bleeding...............	No	Yes
Abdominal pain..............	No	Yes
Ulcer.........................	No	Yes

Psychiatric

Nervousness..................	No	Yes
Depression....................	No	Yes
Insomnia......................	No	Yes

Genitourinary

Frequent Urination.............	No	Yes
Incontinence....................	No	Yes
Blood In urine...................	No	Yes

Musculoskeletal

Joint pain......................	No	Yes
Weakness of muscles..........	No	Yes
Muscle pain/cramps...........	No	Yes
Difficulty Walking............	No	Yes
Arthritis........................	No	Yes

Neurological

Frequent Headaches...........	No	Yes
Recurring headaches..........	No	Yes
Seizures/Convulsions.........	No	Yes
Numbness/Tingling...........	No	Yes
Tremors.......................	No	Yes
Paralysis......................	No	Yes
Stroke.........................	No	Yes
Head Injury....................	No	Yes
Memory loss..................	No	Yes

Endocrine

Glandular/hormone............	No	Yes
Thyroid disease.............	No	Yes
Diabetes........................	No	Yes
Excessive thirst................	No	Yes
Heat/cold intolerance..........	No	Yes

Hematologic/Lymphatic

Slow to heal....................	No	Yes
Easy bruising/bleeding.........	No	Yes
Anemia.........................	No	Yes
Hepatitis........................	No	Yes
HIV.............................	No	Yes

Allergic/immunologic –

Have you ever had a bad reaction to any of the following:

Antibiotics......................	No	Yes
Penicillin........................	No	Yes
Morphine/Demerol/Codeine......	No	Yes
Aspirin...........................	No	Yes
Tetanus or other serum..........	No	Yes
Iodine............................	No	Yes
Shell fish........................	No	Yes
Narcotics........................	No	Yes
Anesthesia......................	No	Yes
Acute Infections................	No	Yes
Latex.............................	No	Yes

Other______________________________

Cancer/Other____

Signature____

Patient/Guardian

Last updated 01/05/11