THE EAR INSTITUTE

Center for the Ear, Hearing & Balance

36867 Cook St., Suite 103 * Palm Desert, CA 92211 • Tel: 760-565-3900

Please fill out and fax back to: 855-505-3900. For any questions, please call: 760-565-3900

PATIENT INFORMATION

Date________________________

Last Name__________________________________Middle Initial____First Name__________________________________

D.O.B.____Age_________ Sex ☐ M ☐ F

Billing Address____City________________________________

State_______Zip________________________E-mail____

Social Security #____

Home Phone (   )________________________________Cell Phone (   )_________________________________

Primary M.D.____ Referring M.D.______________________________________

How did you hear about us? ____

Employer____ Work Phone (   )_________________________

Spouse Name________________________________Employer____

Work Phone (   )_______________________________Cell Phone (   )__________________________________

Contact Person in Case of Emergency (Not Living With You)____

Work Phone (   )_______________________________Cell Phone (   )__________________________________

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the offices of Maya Kato, M.D., a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Patient Name____ ____________Date ______________________

I do ☐ do not ☐ wish to have marketing materials (incl. appointment reminder cards) mailed to my home address.

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Initial

INSURANCE INFORMATION

Primary Insurance____________________________________ Primary Ins. I.D. #__________________________________

Group #____ Union /Local # ____________________________________

Secondary Insurance _________________________________ Secondary Ins. I.D. #_______________________________

Group # ____ Union/Local # _____________________________________

I hereby authorize Dr. Kato to release any and all medical information to the above-named insurance carrier (or to designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. Kato all money to which I am entitled for medical and/or surgical expense related to the service rendered by her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by my assignment. I further agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required.

____ ____

INSURED OR GUARDIAN'S SIGNATURE PATIENT'S SIGNATURE

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INSURANCE SUBSCRIBER INFORMATION

This information is for the person who is the primary holder of the insurance. For example: Both you and your spouse work, but the insurance is from your spouse's employer. This would then be your spouse's information.

Last Name________________________________Middle Initial____First Name________________________________

D.O.B.____Age________ Sex ☐ M ☐ F

Relationship to Patient ____

Address ____

City ____State _________________Zip _______________

Home Phone ( ) ____________________________________Cell Phone ( ) _______________________

Social Security Number ____(Required for billing purposes)

Employer ____Work Phone ( ) ______________________

Address ____

City ____State _________________Zip _______________

If patient is a minor, please complete the following information with the parent / guardian information:

Last Name________________________________Middle Initial____First Name________________________________

D.O.B.____Age________ Sex ☐ M ☐ F

Relationship to Patient ____

Address ____

City ____State _________________Zip _______________

Home Phone ( ) ____________________________________Cell Phone ( ) _______________________

Social Security Number ____(Required for billing purposes)

Employer ____Work Phone ( ) ______________________

Address ____

City ____State _________________Zip _______________

This information is intended only for use by designated individuals. It may contain confidential information protected by local, state, or federal regulations, including HIPPA. Thank you.

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NAME ______________________________ AGE __________ DATE ______________

CHIEF COMPLAINT: Please write a brief description of your main Ear, Nose, Throat, Head, Neck, Balance or Dizziness problem: (The reason for your visit today) ____

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Please check (X) any of the following you have:

- ☐ Heart Disease
- ☐ Asthma
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ COPD/Emphysema
- ☐ Kidney Disease
- ☐ Ulcer Disease
- ☐ Hepatitis
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Bleeding Disorder
- ☐ HIV

OTHER MEDICAL PROBLEMS:

1. ____
2. ____

PREVIOUS SURGERIES:

1. ____
2. ____
3. ____

HAVE YOU SEEN AN EAR, NOSE & THROAT DOCTOR BEFORE?:

☐ Yes ☐ No _______ If yes, Who? ________________________________

If yes, Reason: ____

PHARMACY NAME ______________________ PHONE (   ) ______________________

MEDICATIONS CURRENTLY TAKING:

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

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐ Yes If yes, list below ☐ No

1. ______________________
2. ______________________
3. ______________________
4. ______________________

SOCIAL HISTORY/HABITS:

Marital Status: (Circle one) ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many?___________________________

Have you ever used tobacco? ☐ Yes ☐ No If yes, for how many years? __________________

If you quit, when? ___________________________

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day?_____________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____________________

Family History	Hearing Loss	Cancer	High Blood Pressure	Diabetes	Thyroid Disease	Bleeding Disorder	Heart Disease	Kidney Disease
Patients Father								
Patients Mother								
Patients Father's Parents								
Patients Mother's Parents								
Siblings (brothers/sisters)								
Children								

HISTORY & REVIEW OF SYSTEMS:
PLEASE CHECK (X) THE FOLLOWING SYMPTOMS YOU PRESENTLY HAVE:

EARS	X	SYMPTOMS
Ear Pressure		
Drainage		
Pain		
Dizziness/Vertigo		
Decreased Hearing		
Ringing In Ears		

THROAT	X	SYMPTOMS
Sore Throat		
Voice Change		
Frequent Clearing		
Difficulty Swallowing		

CARDIAC	X	SYMPTOMS
Heart Disease		
High Blood Pressure		
Chest Pain/Pressure		
Heart Murmurs		
Heart Palpitations		

NEUROLOGIC	X	SYMPTOMS
Headaches		
Light Headedness		
Nervous Disorders		
Epilepsy/Seizures		
Strokes		

PULMONARY (LUNG)	X	SYMPTOMS
Shortness Of Breath		
Chronic Cough		
Coughing Up Blood		
Asthma		
Emphysema		

NOSE	X	SYMPTOMS
Runny Nose		
Post Nasal Drip		
Obstruction		
Sinus Pain/Pressure		
Allergies		
Loss Of Sense Smell/ Taste		
Sleep Apnea		
Snoring		

MOUTH	X	SYMPTOMS
Dry Mouth		
Ulcers		

MUSCULAR/SKELETAL	X	SYMPTOMS
Back Pain		
Arthritis/Rheumatism		
Muscle Pain/Weakness		
Osteoporosis		
Jaw Pain/Popping		

THYROID PROBLEMS/ MEDICATION	X	SYMPTOMS
Diabetes		
Thyroid Problems		
Goiter/Nodule		

GASTROINTESTINAL	X	SYMPTOMS
Gastrointestinal		
Weight Loss		
Liver/Cirrhosis		
Hepatitis		
Ulcer		
Heartburn/Reflux		

EXPLANATION: ____

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