PACIFICA
Sarah Vakkalanka, M.D.
EAR | NOSE | THROAT

Last Name: ______________________________ First Name: _________________________M.I.____

Date of Birth: _________________________ Gender: Male · Female

Home Phone: ____________________________ Cell Phone: _________________________________

Email address: ____

Home Address: ____

City: ____________________________________ State: ___________ Zip Code: ____________

Occupation: ______________________________________ Employer: ____________________________

Guardian's Full Name *(if minor)*: ____

Patient SSN: _______________________________ Guardian SSN: _____________________________

Emergency Contact Name: _____________________________ Relationship: ___________________

Phone Number: ________________________________

Primary Care Physician: ___________________________ Phone Number: ______________________

Referring Physician: ______________________________ Phone Number: ______________________

Preferred Pharmacy Name: __________________________ Phone Number: ___________________

How did you hear about our office?

____

Medical History Form

Current Medications (Please include over the counter medications and supplements)

Name of Drug	Dosage (Strength)	Frequency (times per day)

Drug Allergies

Name of Drug	Reaction

If you have **no known allergies** please check this box: ☐

Review of Systems

Please check *yes* if you **currently** have the following symptoms.

ENT	YES		YES
Hearing Loss		Facial Pain	
Ringing in the ears		Loss of Smell	
Room spinning dizziness		Postnasal Drip	
Ear Pain		Snoring	
Ear Discharge		Difficulty Swallowing	
Runny Nose		Pain with Swallowing	
Hard to Breathe Through Nose		Hoarseness	
Itchy Nose		Nose Bleeds	
Lump in neck			

Neurologic	YES	**Cardiovascular**	YES	**General**	YES
Headaches		Chest Pain		Fever	
Numbness		Palpitations		Weight Loss	
Weakness		Shortness of Breath		Night Sweats	
Blurred Vision				Fatigue	
Double Vision					

Genitourinary	YES	**Musculoskeletal**	YES
Frequent Urination		Joint Pain	
Nocturnal Urination		Joint Swelling	
Painful Urination		Limited Mobility	

HIPAA PRIVACY RULES

Authorization of Disclosure in general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. **The patient may revoke or change this authorization at any time with a written request.**

1. I wish to be contacted by Pacifica ENT in the following manner:
   - ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email
2. I give permission for Pacifica ENT to:
   - ☐ Leave a message with detailed information
   - ☐ Send appointment reminders via text message
   - ☐ Mail written communication to my home address
   - ☐ Send written communication to my email address

Signature: ____ Date: ________________

INSURANCE

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account due for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge**. I will notify Pacifica ENT of any changes in my health status or in the above information.**

Signature: ____ Date: ____________

Patient Last Name: _______________________ Patient First Name: _____________________

Guardian's Signature *(if minor)*: ____

BILLING AND FINANCIAL POLICY INFORMATION

Every attempt is made to comply with insurance company's requirements. Since policies and benefits differ among employers and individuals participating with insurance companies, we are unable to know the specifics of your policy. Your insurance company informs all participants that it is ultimately your responsibility to verify benefits and coverage information prior to having any services rendered. Pacifica ENT cannot guarantee the cost of services performed will be covered by your insurance.

Insurance companies require submission of all claims within specified time limits. If you have a change in your insurance, and you fail to inform us of the change, we may not be aware until your insurance company denies a claim. Denials often arrive after the filing limits have expired, preventing us from refiling the claim with another insurance. To limit the charges that you may be responsible for, please ensure that we always have up-to-date information by insurance coverage.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance;
- If you do not have a referral when required and have elected to be seen
- If you are with an insurance company we are not contracted with; or,
- If a claim denial from the insurance company is not able to be resolved.

NO SHOW/ CANCELLATION POLICY

Effective January 1, 2020 there will be a $50.00 fee charged for no shows or for cancelled appointments with less than 24 hour notice. This will be applied to your statement.

SURGERY CANCELLATION POLICY

A scheduling deposit is required prior to any surgery. The deposit may be refunded in part or whole after your insurance company has processed the payment for your claim. Pending you have no balances due to Pacifica ENT.

By signing this form, you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Pacifica ENT or supplier for services rendered.

____ ___________________

Signature of Patient or Responsible Party Date

____

Print name