Boulder Medical Building
12630 Monte Vista Road, Ste 206
Poway, CA 92064
858-674-1165

PATIENT REGISTRATION

PERSONAL

Name ______________________ Date of Birth __________ Male Female

Address ______________________

City ______________________ State ______ Zip __________

Home Phone ______________________ Cell ______________________

Email ______________________ Social Security # ______________________

EMPLOYMENT

Employer ______________________ Work Phone ______________________

PERSON RESPONSIBLE FOR PAYMENT

Name ______________________ Relationship ______________________ DOB __________

Address ______________________ Phone ______________________

IN CASE OF EMERGENCY (Please provide the name of an additional contact person.)

Name ______________________ Relationship ______________________

Address ______________________ Phone ______________________

INSURANCE (You can skip this if we have a copy of your cards.)

❐ PPO ❐ Medicare ❐ HMO ❐ Cash ❐ Other ______________________

Primary Ins Name ______________________ Subscriber ______________________

Secondary Ins Name ______________________ Subscriber ______________________

REFERRAL SOURCE

Who referred you to our office? ❐ Yellow Pages ❐ Insurance ❐ Internet ❐ Friend/Relative ❐ Hospital

❐ Physician ______________________

Which search engine or phone book did you use to find us? ______________________

I acknowledge I have reviewed Rancho ENT's Notice of Privacy Practices.

Signed ______________________ *Date* ______________________

I give my permission for treatment by Dr. Wadhwa or Dr. MacEwan and I give my permission to Rancho Ear, Nose & Throat to release information to my insurance carrier. I authorize my insurance carriers to pay benefits directly to Rancho Ear, Nose & Throat.

Signed ______________________ *Date* ______________________

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Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form.

Full Name____ Appointment Date ________________

❒ Male ❒ Female Date of Birth_________________ Height ___________ Weight __________

Pharmacy Preference (include location) ____

Name of Primary Care (Family) Physician ____

Name of Referring Physician (other than primary care physician) ______________________________

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter, Aspirin, Coumadin, blood thinners, or herbal medications.) ❒ Yes ❒ No **If yes, please list below.** *Include dosages.*

Medication Name	Dosage	How often taken
❒ More on back		

Are you allergic to any medications? ❒ Yes ❒ No **If yes, please list below.**

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia? ❒ Yes ❒ No

If yes, list types of anesthesia and problems you have had __________________________________

Have you had surgeries including Ear, Nose or Throat surgeries? ❒ Yes ❒ No

If yes, list types and when they were done. ____

Have you ever been hospitalized for non-surgical reasons? ❒ Yes ❒ No

If yes, list dates and reasons. ____

What is the main reason you are seeing the doctor today? ________________________________

____

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Medical Information Release Form
(HIPAA Release Form)

Name ____ Date of birth ____________________________

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse ____

Child(ren) ____

Other ____

Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number ________________________________

If unable to reach me:
you may leave a detailed message.
please leave a message asking me to return your call.
____

The best time to reach me is (day) ________________________ between (time) _____________________________

____ _____________________________
Signed *Date*

____ _____________________________
Witness *Date*

Ashish K. Wadhwa, MD
Jennifer MacEwan, MD

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OFFICE FINANCIAL POLICY

At Rancho Ear, Nose and Throat, our focus is on your health. We are committed to providing a patient experience that goes beyond the traditional office visit. Please let us know if you have any questions about our financial policy.

DIAGNOSTIC PROCEDURES

Most exams require additional diagnostic procedures. These tests are separate from the office visit and may be necessary for the proper evaluation and/or treatment of your medical condition. Declining them may impair or delay treatment. Depending on your insurance, the following are cost estimates after insurance adjustment. They may also be subject to a co-pay and/or an out-of-pocket deductible, as directed by your insurance plan.

- Audiogram (hearing test)....................$40 - $85
- Endoscopic Exam (nose or throat) ....$150 - $350
- Initial Office Visit/Consultation....................$100 - $300
- Ultrasound (thyroid or neck) ....$200 - 300

__________ *Please Initial*

Please understand that while our physicians will be considerate of your financial needs, proper evaluation may require certain tests or procedures. Rancho ENT does not modify or negotiate treatment fees, as they are agreed upon by our contract with your insurance provider. Please advise our staff if you do not wish to have these procedures until after you have contacted your insurance for benefit information. The physicians will not modify or negotiate fees during the exam. **If you have questions, please address them to the office manager prior to your appointment.**

INSURANCE BILLING

- I understand Rancho ENT does not accept Medi-Cal (primary or supplement) or CMS.
- I understand I am responsible for all co-pays, coinsurance and deductibles. Follow-up visits are not included with the initial visit.
- Rancho ENT bills secondary insurances as a courtesy. If my insurance does not pay within a reasonable amount of time, I understand I will be responsible for outstanding fees.
- I understand if my HMO or other insurance requires authorization for specific tests or procedures, I must be sure that prior authorization is obtained before receiving such services.

__________ *Please Initial*

MISSED APPOINTMENTS

- Our office makes every effort to provide prompt medical care to all our patients. If you are unable to keep a scheduled appointment, please let us know in advance. A NO-SHOW (when a patient fails to keep a scheduled appointment) will generate a $50 fee.
- If you are delayed and cannot arrive for your appointment on time, please call to advise us of your delay. Any significant delay may require the visit be rescheduled.

__________ *Please Initial*

We understand there may be issues beyond your control and want to be understanding. In the event you have a special circumstance, please contact our office manager.

OTHER

Please be advised Dr. Wadhwa and Dr. MacEwan maintain surgical privileges at Pomerado Hospital and the Rancho Bernardo Surgery Center. Additionally, Dr. Wadhwa and Dr. MacEwan primarily admit patients to the Pomerado Hospital. Dr. Wadhwa and Dr. MacEwan maintain a minority partnership interest in the Rancho Bernardo Surgery Center.

I have read the above and understand that failure to meet my financial obligations may result in the referral of my account to a collection agency.

Name (please print) ______________________________

Signed ______________________________ Date ____________________

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Notification Regarding Testing Results
Lab, Pathology & Imaging

Dear Patient,

Frequently, Rancho Ear, Nose and Throat will request that you complete testing with an outside provider such as a radiology or laboratory/ pathology facility. While it is standard procedure that we receive results from these providers in a timely manner, sometimes it simply does not happen.

Please contact us if you have not heard from us within one week of your testing as we may not have received your results. Please understand we do not receive notification from the facility when testing is initiated.

It is extremely important that you receive your test results, especially if they are abnormal.

We appreciate your cooperation in this matter as we work together to optimize your health and give you the best possible outcome.

Cordially,

Rancho Ears, Nose and Throat

....

I understand my obligation to follow up on test results.

Patient Name____

Signature _______________________________________ Date ______________________