



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

PATIENT REGISTRATION

PERSONAL

Biological gender
assigned at birth:

Name _____ Date of Birth _____ Male Female

****If you have a special request regarding how you'd like to be addressed, please notify the staff.**

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____ Social Security # _____

PHYSICIANS Primary Care & Location _____ Referring _____

EMPLOYER _____ Work Phone _____

PERSON RESPONSIBLE FOR PAYMENT, if other than patient

Name _____ Relationship _____ 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 _____

REFERRAL SOURCE

Who referred you to our office? ☐ Insurance ☐ Internet ☐ Friend/Relative ☐ Hospital ☐ Physician

Which search engine 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 _____

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
<input type="checkbox"/> 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? _____



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

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 Wadhwa, MD
Jennifer MacEwan, MD

Patient Name (please print legibly)

OFFICE FINANCIAL POLICY

At Rancho ENT, our focus is on your health. We are committed to providing a patient experience that goes beyond the traditional office visit. Please let our office manager 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.

- Initial Office Visit/Consultation.....\$100 - \$300
- Diagnostic Audiogram\$40 - \$85
- Endoscopic Exam (listed as surgical procedure on your Explanation of Benefits)\$150 - \$550
- Ultrasound (thyroid or neck)..... \$200 - \$300
- CT Scan.....\$200 - \$450 _____
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, co-insurance 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 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.

Signed _____ Date _____



Patient Name (please print legibly)

Notification Regarding Testing Results Lab, Pathology & Imaging

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.

I understand my obligation to follow up on test results.

Signature _____ Date _____