

# SCENTAA

SOUTHERN CALIFORNIA EARS NOSE THROAT AND ALLERGY

MICHAEL BUBLIK, MD | STEPHEN CABALATUNGAN, PA-C

Facial Plastic Surgery | Otolaryngology | Allergy Clinic

## Patient Information:

Prefix (Circle One): Dr. Miss. Mr. Mrs. Ms. Sir

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Suffix (If applicable): II III IV Jr Sr

Middle Initial: \_\_\_ Maiden Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2 (Apt, Unit, Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ - \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

E-mail: \_\_\_\_\_

Advance Directive: *Please provide if applicable*

Primary Care Physician: \_\_\_\_\_

Referral Source (Select One):

Physician: \_\_\_\_\_

Family/Friend: \_\_\_\_\_

Online: Insurance Website Google Yelp Directory

Social Media: Facebook Instagram Twitter Youtube

Date Of Birth (mm/dd/yyyy): \_\_\_ / \_\_\_ / \_\_\_\_\_

Sex (Circle One): Female Male Other/Unknown

Marital Status: \_\_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

Employment Status: \_\_\_\_\_

Student Status: Full-time Part-time Not Student

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

## Emergency Contact:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Guardian: Y or N HIPPA Consent: Y or N

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

*\*If address same as patient, leave address below blank*

Address Line 1: \_\_\_\_\_

Address Line 2 (Apt, Unit, Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ - \_\_\_\_\_ Country: \_\_\_\_\_

## Responsible Party: (if not patient)

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Date Of Birth (mm/dd/yyyy): \_\_\_ / \_\_\_ / \_\_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

*\*If address same as patient, leave address below blank*

Address Line 1: \_\_\_\_\_

Address Line 2 (Apt, Unit, Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ - \_\_\_\_\_ Country: \_\_\_\_\_

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**Insurance Information:** *(fill in information if insurance cards are not present and provided)*

Primary Insurance Carrier: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Subscriber ID Number: \_\_\_\_\_

Subscriber ID Number: \_\_\_\_\_

Plan Group Number: \_\_\_\_\_

Plan Group Number: \_\_\_\_\_

Plan Group Name: \_\_\_\_\_

Plan Group Name: \_\_\_\_\_

**Pharmacy information:**

Pharmacy Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2 (Apt, Unit, Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ - \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I hereby certify that the above information is true and correct to the best of my knowledge and that I am the above-named patient, and/or the authorized general agent of the above-named patient, whom is authorized to furnish the information requested and seek and authorize healthcare services.

I acknowledge that a Photo ID will be taken, copied, stored, and used to assist in the recognition of the patient, and/or authorized general agent of the patient, per HIPPA guidelines.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Signature Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**In-Office Use:**

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**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**SYMPTOMS YOU ARE HAVING:** \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

Name of Medication	Dosage	How Often Taken

**Medical History:**  Heart Disease  High Cholesterol  Stroke  Diabetes  High Blood Pressure

Heart Attack  Liver Disease  Kidney Disease  Tuberculosis  Hepatitis C  HIV/AIDS  Depression

Cancer (please list): \_\_\_\_\_

Other (please list): \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATION?** \_\_\_ Yes \_\_\_ No If yes, please list below:

Name of Medication	Type of Reaction

**ARE YOU CURRENTLY TAKING BLOOD THINNERS?** \_\_\_ Yes \_\_\_ No If yes, please list below:

Name of Medication

## SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? \_\_\_ Yes \_\_\_ No

If yes, please list type of problems: \_\_\_\_\_

\_\_\_\_\_

List any surgeries you have had (including dates): \_\_\_\_\_

\_\_\_\_\_

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

If yes, list reasons for hospitalizations \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

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## **Authorization to Release Information and Assignment of Benefits**

Please remember that insurance is considered a method of reimbursing for fees paid to the doctor and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay for a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for by your insurance.

I (the patient) consent to the use of stored credit card information to automatically pay for remaining patient balances as put forth in the financial policies.

I directly assign all medical and surgical benefits to Michael Bublik MD APMC and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment to this office immediately.

If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection agency. In the event that your account is referred to such an agency, you will be responsible for all attorney's fees and/or collection fees.

"I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement be as valid as the original. I have read and understand the information of this form. I certify the information is true and correct to the best of my knowledge."

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## STANDARD INSURANCE WAIVER FORM

**PLEASE SUBMIT YOUR CURRENT INSURANCE CARD FOR COPYING**

Our office will file insurance for all reimbursable service, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts.

By signing, I understand that this office will submit claims to my insurance company for services rendered, however, I am ultimately financially responsible for my account. An authorization does not guarantee your coverage is current.

I authorize the release of any medical information necessary to process my claims.

Additionally I authorize payment of medical and surgical benefits directly to Michael Bublik, M.D., PC.

\_\_\_\_\_

**Print Name**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

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## Privacy Notice Acknowledgement

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

By my signature below, I acknowledge that I have read and/or received a copy of this office's HIPPA (Health Insurance Portability and Accountability Act) Privacy Notice, and that a copy is available to me at any time.

I have listed the names(s), relationships(s) and phone numbers of persons I authorize to receive my protected health information:

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (or Authorized Representative) \_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Authorization Representative \_\_\_\_\_  
Relationship to patient

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## CONSENT FORM FOR ePRESCRIBE PROGRAM

### ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Michael Bublik, MD APMC as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. *As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.*

### Consent

By signing this consent form you are agreeing that your provider at Michael Bublik, MD APMC may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Michael Bublik, MD APMC to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Signature Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_