SCENTAA

SOUTHERN CALIFORNIA EARS NOSE THROAT AND ALLERGY

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): _____

_____

_____

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Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No

If yes, list reasons for hospitalizations _____

Height _____Weight _____BP_____/_____

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."

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Signature:_____ **Date:** _____

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:** _____

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Print Signature Name: _____ Relationship to Patient: _____