TUSTIN ENT SINUS & ALLERGY

☐ **Charles K. Oh, M.D.**

☐ **Thomas Huang M.D.**

Date: _____

General Information

Full Name: _____ DOB: _____ Marital Status:_____

If a minor, name of the parent or responsible party:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email: _____ Social Security:_____

Occupation:_____ Employer:_____

Referred By:_____

Primary Care Physician Name: _____ Phone #:_____

*Pharmacy Name:_____ Phone #:_____

Pharmacy Cross Streets:_____ Pharmacy City:_____

Emergency Contact

Full Name:_____ Relationship:_____

Phone:_____

Insurance Information

Primary Ins Company:_____ ID #:_____

Primary Subscriber's Name:_____ Relationship to patient:_____

Secondary Ins Company:_____ ID #:_____

Authorization: *The insurance company is hereby authorized to pay all benefits directly to the attending physician. If special arrangements for payments are needed, they must be made prior to services. I also authorize the release of my medical information to my insurance carrier.*

All patients are responsible for knowing the requirements of their insurance plans, including which labs and radiology facilities they may use, what services are covered, etc. Our staff with assist our patients, but we cannot be responsible for knowing or interpreting the benefits of each individual policy.

Billing Policy: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

I have read the above policies and understand my financial responsibility.

Signature:_____ Date:_____

HIPPA NOTICE: I have been provided the HIPPA notice of privacy practice. (see laminated sheet)

Signature:_____ Date:_____

Tustin ENT Sinus & Allergy Center

Medical Information:

Tell us about the symptom(s) or reason(s) for your appointment:

_____

_____

_____

_____

_____

_____

_____

_____

Estimated Height:_____ Estimated Weight (lbs.)_____

Review Body Symptoms: Please check if you have RECENTLY had any of these symptoms:

- ☐ Abdominal pain
- ☐ Allergies
- ☐ Bleeding problems
- ☐ Chest pain
- ☐ Chills
- ☐ Cough
- ☐ Dizziness
- ☐ Dryness
- ☐ Ear drainage
- ☐ Ear itching
- ☐ Ear fullness or pressure
- ☐ Ear pain
- ☐ Excessive thirst
- ☐ Excess scarring
- ☐ Fainting
- ☐ Fever
- ☐ Hearing loss
- ☐ Itching
- ☐ Loss of vision
- ☐ Nasal congestion
- ☐ Nasal obstruction
- ☐ Neck mass/lump
- ☐ Night sweats
- ☐ Nose bleeding
- ☐ Numbness or tingling
- ☐ Postnasal drip
- ☐ Rash
- ☐ Ringing
- ☐ Runny nose
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sneezing
- ☐ Sore throat
- ☐ Spinning
- ☐ Suspicious lesions
- ☐ Swallowing difficulty
- ☐ Thyroid problems
- ☐ Ulcer/growths
- ☐ Unexplained weight gain
- ☐ Urticaria
- ☐ Vertigo
- ☐ Vision change
- ☐ Voice problems
- ☐ Weakness
- ☐ Weight loss

Past Medical History: Were you ever diagnosed with the following problems?

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back or spine problems
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Glaucoma
- ☐ Head injury
- ☐ Hearing loss
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis or liver problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostates problems
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Others: _____ _____

When was the last time you got a flu shot? _____

Past Surgical History

What surgeries have you previously undergone and when were they performed?

_____

_____

Social History:

Have you ever smoked? _____ How much? _____ How many years? _____
When did you quit? _____ Alcohol intake? _____ Illicit drugs? _____
Occupation and/or hobbies: _____ Children: _____ Pets: _____

Family Medical History: (please circle)

Cancer:_____	Early Hearing Loss	Allergies
Thyroid problems	Sleep Apnea	Others:
High blood pressure	Diabetes	_____

Medication Allergies: Please list any medication allergies and specific reaction when taken:

_____

_____

List below or give a copy of the medications that you **CURRENTLY** take:

_____

_____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Tustin ENT Sinus & Allergy. When you schedule an appointment we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective January 1, 2023

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charge a $40.00 fee. Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee. If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Tustin Ent Sinus & Allergy. Any new patient who fails to show for their initial visit will not be rescheduled. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact our office, should it be after regular business hours you may leave a detailed voice message.

Tustin ENT Sinus & Allergy Center
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Tustin, CA 92780
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Korean: (657)720-1910

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Date: _____

Printed Name: _____

Signature (Parent/Legal Guardian): _____