



RIVIERA ENT

PATIENT DEMOGRAPHIC FORM

Riviera ENT
1819 State St, Ste A
Santa Barbara CA, 93101
Phone:(805)327-6673
Fax:(805)679-5183

Patient's Last Name _____ **First Name** _____ **Middle Initial** _____

How would you prefer we address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

SSN: _____ Date of Birth: _____/_____/_____

Preferred language(s): _____

How to reach you:

Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Home Phone _____ 1st 2nd 3rd 4th choice to contact. Okay to leave messages?

Day Phone _____ 1st 2nd 3rd 4th choice to contact. Okay to leave messages?

Cell Phone _____ 1st 2nd 3rd 4th choice to contact. Okay to leave messages?

E-mail Address _____ 1st 2nd 3rd 4th choice to contact. Okay to leave messages?

Demographics:

Pronoun: He She They Other: _____ Sex at birth: Male Female Other: _____ Decline

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Decline

Ethnicity: Hispanic Non-Hispanic Other: _____ Decline

Marital Status: Single Married Divorced Widowed Separated

Name of Spouse/Parent/Legal Guardian _____ DOB _____

For a child, custody is held by: Mother Father Other (describe here): _____

Student Status: N/A Part-Time Full-Time Daycare

Employer: _____ Employer Address: _____

What is or was your occupation? _____ Retired?

Emergency Contact and relationship: _____ Phone #: _____

Pharmacy Name (Include Address &/or Phone): _____

Preferred Lab for blood tests: Quest PDL Other _____ Doctor you are here to see: Dr. Culver Dr. Taylor

How did you hear about us? _____

Name/City/Phone of your Primary Care Physician/Pediatrician:

Name/City/Phone of the referring Physician (if different):

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____

Policy Holder DOB _____

Plan Name _____

Policy Holder ID# _____ Patient's Policy ID# _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____

Ins. Co. Phone Number _____ Effective Date _____

Deductible \$ _____ Specialist Co-pay Amount \$ _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____

Policy Holder DOB _____

Plan Name _____

Policy Holder ID# _____ Patient's Policy ID# _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____

Ins. Co. Phone Number _____ Effective Date _____

Deductible \$ _____ Specialist Co-pay Amount \$ _____

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

I acknowledge receipt of the Riviera ENT Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA), being adhered to by Riviera ENT.

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____



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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day’s services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form. When the provider you are scheduled to see does not participate with your insurance, your plan may not cover out-of-network services, leaving you to pay the full cost. If your plan does cover out-of-network services, you may be assessed a higher co-pay, deductible and co-insurance for out-of-network care. You will be responsible to pay these higher amounts plus any difference between the allowed amount and the amount the out-of-network provider charges for the service. Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Riviera ENT for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Riviera ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Riviera ENT will not be involved with separation or divorce disputes.
- *You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.*

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient’s Name: _____ DOB: _____
 Responsible Party Signature: _____ Date: _____
 Print Name: _____ Relationship: _____



RIVIERA ENT

PATIENT NOTIFICATION

Riviera ENT
1819 State St, Ste A
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In order to properly evaluate and treat our patients, it is often necessary for our physicians to perform certain in-office procedures as either a part of a patient’s diagnostic work-up and/or as treatment. These procedures will only be performed if it is determined to be necessary for the treatment and/or complete evaluation of your medical condition(s). Prior to performing any in-office procedures, your physician will make you aware and obtain your verbal consent as well as written consent where appropriate. On your bill you may see separate charges in addition to your office visit charge. Although these procedures are performed in the office, these often have billing codes that are listed as “surgery” on your explanation of benefits. While generally all charges are submitted through insurance when applicable, not all charges may be fully covered.

These procedures can include but may not be limited to:

- Nasal endoscopy
- Flexible laryngoscopy
- Tympanometry
- Audiometry
- Biopsy of a mass or lesion
- Cerumen (Wax) Removal
- Nasal cauterization
- Foreign Body Removal
- Fine Needle Aspiration
- Myringotomy
- Closed Reduction of Nasal Fracture
- Complex Wound Closure
- Tongue Tie and/or Lip Tie Release

These services are billed as an **additional charge** from the office visit and additional coinsurance and/or deductible amounts may apply.

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO RIVIERA ENT, P.C. FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I HEREBY AUTHORIZE RIVIERA ENT PHYSICIANS AS HEALTH CARE PROVIDERS TO RELEASE ALL MEDICAL AND FINANCIAL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL. THIS AGREEMENT IS VALID FROM TODAY’S DATE AND REMAINS IN EFFECT UNTIL I, THE PATIENT, REVOKE THIS AGREEMENT.

BY SIGNING BELOW, I HAVE READ AND UNDERSTAND THE TERMS SPELLED OUT IN THE FINANCIAL AGREEMENT DESCRIBED ABOVE.

Patient’s Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____



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PATIENT HISTORY FORM

Patient's Last Name _____ **First Name** _____ **Middle Initial** _____

MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

No Medical / Surgical History

Cardiovascular:	Yes	<u>Management</u>	Immunologic:	Yes	<u>Management</u>
Coronary artery (heart)disease	<input type="checkbox"/>	_____	Autoimmune disorder	<input type="checkbox"/>	_____
Elevated cholesterol (hyperlipidemia)	<input type="checkbox"/>	_____	Immune deficiency or disorder	<input type="checkbox"/>	_____
High blood pressure (hypertension)	<input type="checkbox"/>	_____	Infectious Disease:		
Gastrointestinal:			Mononucleosis	<input type="checkbox"/>	_____
Hepatitis/ liver Issues	<input type="checkbox"/>	_____	Lyme disease	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	_____	Metabolic/endocrine:		
Gastroesophageal reflux	<input type="checkbox"/>	_____	Diabetes Type: _____	<input type="checkbox"/>	_____
Genitourinary:			Thyroid deficiency (hypothyroidism)	<input type="checkbox"/>	_____
Prostate enlargement	<input type="checkbox"/>	_____	Thyroid excess (hyperthyroidism)	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	_____	Neoplastic:		
Renal/kidney failure	<input type="checkbox"/>	_____	Cancer Type: _____	<input type="checkbox"/>	_____
Eye / Ear / Nose / Throat:			Neurologic:		
Cataracts or glaucoma	<input type="checkbox"/>	_____	Migraine	<input type="checkbox"/>	_____
Chronic ear infections (otitis media)	<input type="checkbox"/>	_____	Obstetric:		
Hearing loss	<input type="checkbox"/>	_____	Pregnancy Date(s): _____	<input type="checkbox"/>	_____
Sinus problems (chronic sinusitis)	<input type="checkbox"/>	_____	Psychiatric:		
Nasal polyps	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	_____
Nasal allergies	<input type="checkbox"/>	_____	Major Depression	<input type="checkbox"/>	_____
Recurrent tonsillitis	<input type="checkbox"/>	_____	Pulmonary:		
Tinnitus (noise in ears)	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	_____
Tongue or lip tie	<input type="checkbox"/>	_____	COPD	<input type="checkbox"/>	_____
Vertigo/ dizziness	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	_____
Hematologic :			Sleep Apnea	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	_____			

Other medical conditions you have had: _____

Surgeries you have had (circle and indicate approximate year):

ENT surgeries: Tonsillectomy/Adenoidectomy * Ear tubes * Stapedectomy * Mastoidectomy * Eardrum repair * Septoplasty * Rhinoplasty * Sinus Surgery * Nasal Polypectomy * Thyroidectomy * Neck mass excision * Tongue/lip tie clipping

Non-ENT surgeries: Gallbladder removal * Appendix removal * Hernia repair * Hysterectomy * Caesarean section * Heart valve replacement * Other heart surgery * Cataract surgery * Back surgery * Neck surgery * Joint replacement

Other surgeries you have had: _____

LIST ALL MEDICATIONS YOU ARE TAKING_(Prescription, over-the-counter or herbal):

Allow Riviera ENT to obtain medication history via electronic means directly from insurer/pharmacy _____ initial here

No current medications

Medication	Dosage	How often taken	Medication	Dosage	How often taken

ALLERGIES? No Allergies

Allergies to Medications	Type of Reaction	Allergies to Medications	Type of Reaction

Have you ever had an allergy test? Yes No

Have you ever taken allergy shots? Yes No

HABITS:

Smoking? Never Prior Current Exposure to second-hand smoke?

If current smoker: # years smoking _____ # cigarettes/day _____ Vaping? Do you want to quit?

If former smoker: # years since quitting _____ # years smoking _____ # cigarettes/day _____

Marijuana or other recreational drug? Never Prior Current

List current frequency of use including vaping _____

Alcohol? Never Prior Current

If currently drinking, amount and type drink _____ per day week year

Caffeine consumption? Yes No **Type:** _____ **Amount per day?** _____

FAMILY HISTORY of:

- ADD/ADHD
- Alcoholism
- Allergies
- Alzheimer’s Disease
- Anesthesia Complication
- Asthma
- Autism
- Blood disease
- Coronary artery (heart) disease
- Cancer Type: _____

Who

- Stroke
- Depression
- Developmental delay
- Diabetes
- Eczema
- Hearing loss
- High cholesterol
- High blood pressure
- Learning disability
- Mental illness

Who

- Migraines
- Obesity
- Osteoarthritis
- Osteoporosis
- Renal disease
- Seizure disorder
- Sleep apnea
- Tongue/lip tie
- Vascular disease
- Other conditions:

Who

Responsible Party Signature: _____

Date: _____

Print Name: _____

Relationship: _____



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REVIEW OF SYSTEMS (CURRENT PROBLEMS) FORM

Patient's Last Name _____ First Name _____ Middle Initial _____

What brings you in today? _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

No Yes

- Fatigue
- Fever
- Night sweats
- Weight loss
- Weight gain

Eye problems

No Yes

- Double vision
- Itchy eyes
- Redness

Ear problems

No Yes

- Drainage
- Hearing loss
- Infections
- Dizziness
- Itchiness
- Exposure to Excessive Noise
- Ear pain or pressure
- Tinnitus /noise in ears

Nose & Sinus problems

No Yes

- Congestion
- Facial Pain
- Mouth Breathing
- Nose Bleeds
- Sneezing
- Runny Nose
- Post Nasal Drainage

Mouth & Throat problems

No Yes

- Difficulty Swallowing
- Sleep Apnea
- Snoring
- Sore Throat
- Hoarseness
- Sores/Ulcers in Mouth

Heart or circulation problems

No Yes

- Heart Murmur
- Chest pain
- Swelling of Ankles/Edema
- Blacking Out
- Irregular Heartbeat/Palpitations

Lung or respiratory problems

No Yes

- Cough
- Shortness of Breath
- Wheezing

Musculoskeletal:

No Yes

- Leg pain

Stomach problems

No Yes

- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

Brain or Nervous system problems

No Yes

- Headache
- Seizures
- Focal Weakness
- Numbness

Glands & Hormone problems

No Yes

- Heat Intolerance
- Cold Intolerance
- Neck Enlargement/Goiter

Blood or Lymph nodes problems

No Yes

- Easy Bleeding
- Easy Bruising

Allergy problems

No Yes

- Food Allergies
- Bee Sting Allergies
- Environmental Allergies
- Urticaria / Hives

Skin

No Yes

- Itchy Skin/ Pruritis
- Rash
- Contact Allergy

Other concerns:

Responsible Party Name: _____

Relationship to Patient: _____

Responsible Party Signature: _____

Date: _____