

Randall K. Wenokur. M.D. Lloyd C. Ford, M.D. Benjamin M. Loos, M.D. Joshua K. Au, M.D.

**PATIENT INFORMATION**

Patient Name: Date of Birth: / /

Home Address:

City: State: Zip Code:

Home Phone: Cellular Phone (alternate):

Employer: Work Phone:

Patient's Email Address:

**SPOUSE/PARENT INFORMATION:**

Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor, who to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURED PARTY (GUARANTOR)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Name of Insurance: ID#: Group\*

Secondary Insurance: ID#: Group #:

**PLEASE SIGN AND RETURN TO THE RECEPTIONIST**

I, understand, assign directly to Contra Costa ENT Medical Associates, all surgical and medical benefits, if any, otherwise billable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by my insurance. **I** hereby authorize Contra Costa ENT Medical Associates to release all information necessary to secure the payment of benefits.

Patient Signature (or person authorized to sign for patient) Date



**OTOLARYNGOLOGY/HEAD AND NECK SURGERY**

**NEW PATIENT HISTORY FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: / /

Age: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and location of pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ALL MEDICATIONS YOU TAKE: (you may attach list)**

|  |  |  |
| --- | --- | --- |
| NAME OF MEDICATION | DOSE | FREQUENCY |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**LIST ALL ALLERGIES: (you may attach list)**

|  |  |
| --- | --- |
| DRUG | REACTION |
|  |  |
|  |  |
|  |  |
|  |  |

**PAST SURGICAL HISTORY: List ALL previous surgeries you have had**

|  |  |
| --- | --- |
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |
| 7. | 8. |

**PAST MEDICAL HISTORY** **MARK HERE \_\_\_\_\_\_\_ IF ALL BELOW ARE NEGATIVE**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_ Hypertension | \_\_\_\_\_\_ Sleep Apnea | \_\_\_\_\_\_ Renal Failure |
| \_\_\_\_\_\_ Coronary Artery Disease | \_\_\_\_\_\_ Reflux Disease | \_\_\_\_\_\_ Kidney Stones |
| \_\_\_\_\_\_ Heart Attack | \_\_\_\_\_\_ Hepatitis | \_\_\_\_\_\_ Anemia |
| \_\_\_\_\_\_ Artrial Fibrillation | \_\_\_\_\_\_ Diabetes | \_\_\_\_\_\_ Clotting Problem |
| \_\_\_\_\_\_ Seizures | \_\_\_\_\_\_ Multiple Sclerosis | \_\_\_\_\_\_ HIV/AIDS |
| \_\_\_\_\_\_ COPD | \_\_\_\_\_\_ Tuberculosis | \_\_\_\_\_\_ Stroke |
| \_\_\_\_\_\_ Asthma | \_\_\_\_\_\_ Migraine | \_\_\_\_\_\_ Depression |
| \_\_\_\_\_\_ Arthritis | \_\_\_\_\_\_ Thyroid Disease | \_\_\_\_\_\_ Anxiety |
| \_\_\_\_\_\_ High Cholesterol  | \_\_\_\_\_\_ Kidney Disease | \_\_\_\_\_\_ Gallbladder Disease |
|  |  | \_\_\_\_\_\_ Glaucoma |

Cancer Type(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

|  |  |
| --- | --- |
| \_\_\_\_\_\_ Hypertension | \_\_\_\_\_\_ Cancer Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_ Heart Disease | \_\_\_\_\_\_ Diabetes |
| \_\_\_\_\_\_ Tuberculosis | \_\_\_\_\_\_ Head and Neck Cancer |
| \_\_\_\_\_\_ Acoustic Tumor | \_\_\_\_\_\_ Otosclerosis  |

**SOCIAL HISTROY**

|  |
| --- |
| What is your primary occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tobacco use: \_\_\_ Yes \_\_\_ No \_\_\_ Former |
| Ever tried to quit? \_\_\_ Yes \_\_\_ No When did you quit? \_\_\_\_\_\_\_ Years Smoked: \_\_\_\_\_ Freq: \_\_\_\_\_\_ (daily, wk, mth) |
| Alcohol use: \_\_\_ Yes \_\_\_ No \_\_\_ Former Type: \_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_ |
| Caffeine use: \_\_\_ Yes \_\_\_ No Type:\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_ |
| Are you pregnant: \_\_\_ Yes \_\_\_ No |
|  |

**OTHER SYMPTOM REVIEW** (circle or highlight those that you are experiencing)

**MARK HERE \_\_\_\_\_\_\_ IF ALL BELOW ARE NEGATIVE**

**General:** fatigue, Fever, Night sweats, Weight gain, Weight loss

**Otolaryngologic:** Ear ringing, Ear pain, Ear fullness/pressure, Nasal drainage, Nasal bleeding, Post nasal

drip, Watery eyes, Sneezing, Snoring, Stopping breathing while asleep, Morning headaches, Difficulty

swallowing, Painful swallowing, Hoarseness

**Respiratory:** Cough, Sputum, Shortness of breath, Wheezing

**Heart:** Chest pain, irregular heartbeat

**Stomach/Intestines:** Abdominal pain, Constipation, Blood in stool, Diarrhea, Heartburn

**Endocrine:** Cold intolerance, Heat intolerance, Neck/Thyroid swelling

**Neuro/Psych:** Dizziness, Headache, Focal weakness, Numbness and Tingling

**Skin:** Rash, Frequent skin infections, Itchiness

Musculoskeletal: Back pain, Muscle weakness, Muscle ache/pain

**Hematology:** Bleeding, Easy bruising, Lymph node swelling

**Allergies:** Environmental allergies, Food allergies



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**MISSSED/CANCELLED APPOINTMENT POLICY**

**Missed/Cancelled Doctor Appointment**

Beginning on February 1, 2016, Contra Costa E.N.T., Medical Associates will charge a $50.00 fee for

any appointment not cancelled or rescheduled prior to 24 hours of the appointment.

**Missed/Cancelled Hearing Test**

For appointments that include a hearing test with the Audiologist in our Walnut Creek or Concord

office, there is a $75.00 fee for any appointment missed without 48 hour notice or cancellation.

These fees are not covered by insurance; therefore you will be responsible to pay this fee.

**Returned Check Policy**

Contra Costa E.N.T., will charge a $30.00 return check fee for all returned checks.

I have read and understand the above terms and will adhere to this agreement.

Patient Signature (or person authorized to sign for the patient) Date

Printed Name

|  |  |  |  |
| --- | --- | --- | --- |
| 2700 Grant St, Suite 104Concord, Ca, 94520 | 365 Lennon Lane, Suite 280Walnut Creek, Ca, 94598 | 2400 Balfour Rd. Suite 300Brentwood, Ca, 94513 | 2301 Camino Ramon #205San Ramon, Ca, 94583 |
| P: 925.685.7400 | P: 925.932.3112 | P: 925.685.7400 | P: 925.685.7400 |
| F: 925.685.0917 | F: 925.932.3317 | F: 925.685.0917 | F: 925.685.0917 |



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**CONSENT FOR ADDITIONAL OFFICE PROCEDURES**

There are a number of procedures performed in our office which are necessary as either a part of your diagnostic work-up and/or as treatment. On your bill, you may see separate charges in addition to your office visit charge. Often these have billing codes that are listed as "surgery" and may seem confusing on the bill. All the charges are submitted to your insurance, but not all may be covered equally. These procedures will only be done if it is determined to be necessary for the treatment and/or evaluation of your condition. Prior to doing any of these procedures, your doctor will make you aware. These procedures are as follows, but not limited to:

Nasal Endoscopy
Fiberoptic Laryngoscopy
Audiogram
Tympanometry
Biopsy of mass/lesion
Cerumen (wax) Impaction Removal

Please sign and print name that you have read and understand the terms described above.

Patient Signature (or person authorized to sign for the patient) Date

Printed Name

|  |  |  |  |
| --- | --- | --- | --- |
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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

I, (Print Name)

Acknowlege that I have received a copy of the Notice of Privacy Practice.

Patient Signature Date

If patient is a minor, parent or legal guardian must sign.

|  |  |
| --- | --- |
|  |  |
| Parent or Legal Guardian  | Date |
|  |  |
|  |  |
|  |  |
| Relationship to Patient  | Date |

If patient is NOT a minor, but under the care of a friend, relative or caregiver, sign here.

|  |  |
| --- | --- |
|  |  |
| Signature  | Date |
|  |  |
|  |  |
|  |  |
| Relationship to Patient  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 2700 Grant St, Suite 104Concord, Ca, 94520 | 365 Lennon Lane, Suite 280Walnut Creek, Ca, 94598 | 2400 Balfour Rd. Suite 300Brentwood, Ca, 94513 | 2301 Camino Ramon #205San Ramon, Ca, 94583 |
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To Whom it May Concern:

We are happy to be able to provide a TeleMedicine appointment for you through the website Zoom. Zoom can be accessed through your online device at <https://zoom.us/signup>

If you agree to the following policy, please respond to this email confirming the date and the time of your appointment. You will then be sent a link via email that can be used from any smartphone or computer with a video camera.

By replying to this email, you agree to:

* Please note that all deductible/coinsurance will be billed through our billing department with BASS, our regular financial policies will apply regarding payment. For new patients we require a credit card on file for no show visits.
* Login prior to the assigned time and wait for the doctor to join the virtual waiting room.
* No show TeleMedicine New Patient and follow up visits will be charged $50.00 no show fee.
* You understand that TeleMedicine has limits and cannot always replace an in-office visit, but you are willing to accept all risks associated with these limits.
* You consent to treatment via the TeleMedicine platform as per your already assigned agreement with our office.
* If the doctor believes you need to be seen in the office, they will have you set up with a future appointment. All office visits associated fees will apply per insurance requirements.

|  |  |
| --- | --- |
| Date of TeleMedicine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Time of TeleMedicine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_ |
| Parents Name (if Patient is a Minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature (if patients is a minor than parent’s signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Cell Phone Number for TeleMedicine Invitation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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**COVID-19 informed consent office visit agreement**

I, the undersigned patient, consent to an in-person consultation by Contra Costa ENT to perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations at this time, despite my own efforts and those of Contra Coast ENT, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in the Contra Costa ENT office or in a hospital, may result in a more severe case of CODID-19 than I might have had without the procedure.

I also understand in-person consultations or office visits at this time increase the risk of my transmission of COVID-19 to Contra Costa ENT and its staff. This virus has a long incubation period, there may be as yet to know aspects of its transmissions, and I realize that I may be contagious whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at Contra Costa ENT, I accept that the Contra Costa ENT will implement infection-control procedures with which I must comply, before, during and after my consultation, visit or procedure, for my own protection as well as that of Contra Costa ENT and its staff. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

I have informed Contra Costa ENT of any COVID-19 testing I or any person living with me during the past 14 day has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to Contra Costa ENT. I understand that Contra Costa ENT may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the result of that testing must be satisfactory to Contra Coast ENT, before I may receive my procedures.

I confirm neither I nor any individual living with me has and of the COVID-19 symptoms listed by the Centers for Disease Control <https://www.cdc.gov/coronavirus/2019-ncov/index.html>, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms, and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

All topics above have been discussed above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure performed now. If I am the parent\, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient’s behalf.

Patient/Authorized Representative Signature & Initials Print Name & Date

**Notice and Disclaimer:** *Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care.*