Premier ENT, Inc.
Premier ENT and Premier Cosmetics
Sharen K. Jeffries, M.D.
255 Terracina Boulevard, Suite 201, Redlands, CA 92373
Tel: (909) 793-2500
www.premierentmedical.com

Patient Information

Date:	☐New ☐Change	Doctor: SHAREN K. JEFFRIES, M.D.
Patient's Name (Last, First, MI):		
Address:		

City:	State:	Zip:	E-mail:

Home Telephone #:	Cell/Other Telephone #:	Work Telephone #:
Employer:		

☐Male ☐Female	Marital Status:	Date of Birth:	Age:	Social Security #:

Emergency Contact:	Telephone #:
Insurance:	ID #:

RESPONSIBLE PARTY FOR BILLING: (IF DIFFERENT THAN ABOVE)

Name (Last, First, MI):			
Address:	City:	State:	Zip:

Patients Relationship To Responsible Party**:**
☐ Self ☐ Spouse ☐ Child ☐ Other

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

Please Initial:

______ In order to control your cost of billings, we request that our charges for office visits be paid at the conclusion of each visit**.**

______ If this account is assigned to an attorney for collection and/ or suit, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection.

______ To the extent necessary to determine liability for payment and to obtain reimbursement, I authorized disclosure of portions of the patient's record.

I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled including Medicare's, private insurance, and other health plans to: Premier ENT, A Medical Corp. Sharen K. Jeffries, M.D.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment. I hereby authorize evaluation and treatment by Dr. Sharen Jeffries.

Signed:	Date:

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Privacy Agreement (HIPAA)

PLEASE READ IT CAREFULLY
The Health Insurance Portability Act of 1996 (“HIPPA”) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by use in any form, whether electronically, on paper, or verbally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for entities that misuse health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may disclose your medical records for each of the following:

- • Treatment: Providing, coordinating or managing healthcare related services for one or more healthcare providers, such as a physical exam.
- • Payment: Activities such as obtaining reimbursement for services, confirming coverage, billing or collecting procedures and utilization review.
- • Healthcare Operations: Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifying information.

We may contact you to provide appointment reminders or treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosure of protected health information, including those related to disclosure to family members, friends, or any other person identified by you. We must abide by such restrictions, unless you remove the restriction in writing. However, we are not required to agree to the restriction.
- The right to reasonable requests to receive confidential communication of protection of health information from us by alternative means or at alternative locations.
- The right to inspect or copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

I understand that as part of my healthcare, this organization originates and maintains healthcare records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans or care regarding future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals that contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a “Notice of Privacy Practices”, which provides a more complete description of the information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and that prior to implementation, will mail a copy of the revised notice to me at the address I have previously provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or other health-related operations and that the organization is not required to agree to the restrictions requested. I acknowledge receipt of this organization’s “Notice of Privacy Practices”. (Notice effective date or versions: August 30, 2007)

________________	________________	________
Patient Name (Print)	Signature	Date

Patient Review of Systems

Patient Name: ______________________ DOB: __________ Date: __________

Referring Doctor: ______________________ Height: __________ Weight: __________

Occupation: ______________________ Race: __________ Ethnicity: __________

Chief Complaint: (reason for today's visit): ______________________

Please list any prior major illnesses or injuries: ______________________

____

Have you or any family member ever had a problem with anesthesia? ☐Yes ☐No

Explain: ______________________

Have you or a family member ever had a history of excessive bleeding? ☐Yes ☐No

Explain ______________________

Have you ever smoked? ☐Yes ☐No How much? ______ Per day How long? ______ years

DO you drink alcohol? ☐Yes ☐No How much? ______ Per day How long? ______ years

Do you have any allergies or reactions to medications? ☐Yes ☐No

Explain ______________________

Have you had any surgeries or hospitalizations? ☐Yes ☐No

Explain ______________________

Please list medications you currently take including aspirin:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you currently, or have you ever, experienced problems with following? Please check:

Constitutional:

Weight Gain	☐Yes	☐No
Weight Loss	☐Yes	☐No
Night Sweats	☐Yes	☐No
Insomnia	☐Yes	☐No

Ear, Nose, Throat:

Hearing Loss	☐Yes	☐No
Ringing noise	☐Yes	☐No
Nasal congestion	☐Yes	☐No
Sinus problems	☐Yes	☐No
Trouble swallowing	☐Yes	☐No
Hoarseness	☐Yes	☐No

Allergic/Immunologic:

Sneezing	☐Yes	☐No
Itchy eyes/nose/throat	☐Yes	☐No
Allergy Shots	☐Yes	☐No
Skin Rash	☐Yes	☐No
HIV	☐Yes	☐No

Cardiovascular:

High cholesterol	☐Yes	☐No
Heart attack/chest pain	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No
Heart Murmur	☐Yes	☐No
High Blood Pressure	☐Yes	☐No

Neurological

Numbness	☐Yes	☐No
Weakness	☐Yes	☐No
Stroke	☐Yes	☐No
Headache	☐Yes	☐No

Respiratory:

Trouble breathing	☐Yes	☐No
Snoring	☐Yes	☐No
Asthma	☐Yes	☐No
Cough-up blood	☐Yes	☐No
Tuberculosis (TB)	☐Yes	☐No
Pneumonia/Bronchitis	☐Yes	☐No

Gastrointestinal:

Indigestion/Heartburn	☐Yes	☐No
Ulcers	☐Yes	☐No
Hepatitis	☐Yes	☐No
Jaundice	☐Yes	☐No
Bloody or Black stool	☐Yes	☐No

Genitourinary:

Bladder control	☐Yes	☐No
Prostate disease	☐Yes	☐No
Kidney disease	☐Yes	☐No

Musculoskeletal:

Arthritis	☐Yes	☐No

Eyes:

Double vision	☐Yes	☐No
Vision loss	☐Yes	☐No
Glasses	☐Yes	☐No

Endocrine:

Diabetes	☐Yes	☐No
Thyroid disease	☐Yes	☐No

Hematologic:

Bleeding disorder	☐Yes	☐No
Anemia	☐Yes	☐No

Psychiatric:

Depression	☐Yes	☐No
Other	☐Yes	☐No

______________________ ______________________ ______________________

Patient Name (Print) Signature Date