Welcome!

We look forward to seeing you.

Please complete the New Patient paperwork entirely and return to our office prior to your scheduled appointment. You may drop it off to our office or email to our secure email address at rdgsinuscenter@shastaent.net.

Having your intake complete prior to your appointment gives our office staff time to set up your patient file, verify your insurance benefits and most importantly, decrease your wait time to keep our practice on schedule.

If you are unable to return your paperwork prior to your appointment, please arrive 20 minutes early.

Please have your current Insurance card(s) and Driver's License with you at the time of your appointment.

Sinus Patients: If you have had a Sinus or Head **CT Scan, MRI or X-ray**, please bring your **FILMS or CD AND REPORT** to your initial appointment.

Our office will assist you in obtaining these records. If you do not get the records prior to your appointment, you will be rescheduled.

If you are unable to keep the scheduled appointment, please contact our office to cancel or reschedule 24-48 hrs prior. This allows us to fill your appointment time. In the scenario that a no call or no show happens, a **$50** dollars fee will be incurred. **No future appointment will be scheduled until payment is received.**

Thank you, Dr. Domb & Staff

Shasta ent Specialists

Redding sinus Center

George H. Domb, MD
2125 Court Street
Redding, CA 96001
Phone: 530-242-5600
Fax: 530-242-5605

PLEASE COMPLETE ALL INFORMATION BELOW, THANK YOU.

Today's Date: _____

Patient's Name: _____ **Gender:** ☐ Male ☐ Female
Last First MI

Patient Mailing Address: _____
Street / P.O. Box City State Zip Code

Best Phone #: _____ **Alternate #:** _____
☐ Home ☐ Cell ☐ Work ☐ Spouse ☐ Home ☐ Cell ☐ Work ☐ Spouse

Date of Birth: _____ **Social Security #:** _____

Employer: _____ **Occupation:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Spouse's Name:** _____

RACE: ☐ American Indian ☐ Asian ☐ African American ☐ Native American ☐ Caucasian ☐ Other: _____

ETHNICITY: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Email Address: _____ **Can we communicate with you via Email?** ☐ YES ☐ NO

If the patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ **Social Security #:** _____

Best Phone # (if different from above): _____ ☐ Home ☐ Cell ☐ Work ☐ Spouse

Address (if different from above): _____
Street /P.O. Box City State Zip Code

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship to Patient:** _____

Best Phone #: _____ **Alternate #:** _____
☐ Home ☐ Cell ☐ Work ☐ Spouse ☐ Home ☐ Cell ☐ Work ☐ Spouse

Referring Physician: _____ **Primary Care Physician:** _____

Preferred Pharmacy: _____

Reviewed by Employee: _____

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PRIMARY Insurance Information:

Insurance Company Name: _____ **Effective Date:** _____

Claims Mailing Address: _____
Street / P.O. Box City State Zip Code

Policy ID#: _____ **Group #:** _____

Policy Holder's Name: _____ **DOB:** _____ **Social Security #:** _____

Policy Holder's Address: _____
Street / P.O. Box City State Zip Code

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY Insurance Information:

Insurance Company Name: _____ **Effective Date:** _____

Claims Mailing Address: _____
Street / P.O. Box City State Zip Code

Policy ID#: _____ **Group #:** _____

Policy Holder's Name: _____ **DOB:** _____ **Social Security #:** _____

Policy Holder's Address: _____
Street / P.O. Box City State Zip Code

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Assignment / Acknowledgement / Authorization:

I hereby authorize the submission of insurance claim forms along with the medical records necessary to obtain payment from my insurance company. I hereby authorize payment of insurance benefits to be made to ***Shasta ENT Specialists*** for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment.

I acknowledge that I have reviewed/received this office's notice of privacy practices, which explains how my medical information will be used and disclosed.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under general or special instructions of the physician.

Responsibility Party Signature: _____ **Date:** _____

Reviewed by Employee: _____

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MEDICAL INFORMATION FORM

PLEASE COMPLETE: **Today's Date:** _____

Patient's Name: _____ **Gender:** ☐ Male ☐ Female

Date of Birth: _____ **Family Doctor:** _____ **Referred by:** _____

Reason for your visit: _____

Have you had a Sinus/Head CT / MRI or X-Ray done? YES NO **Location:** MD Imaging Advanced Imaging Other:

PLEASE CHECK ANY CURRENT SYMPTOMS

1. **EARS:**
   - _____ Itchy
   - _____ Pain
   - _____ Drainage
   - _____ Hearing Loss
   - _____ Ringing
   - _____ Dizziness

2. **NOSE & SINUS:**
   - _____ Runny Nose
   - _____ Post-Nasal Drip
   - _____ Stuffy or Congested
   - _____ Nosebleeds
   - _____ Problems with Sense of Smell
   - _____ Polyps

3. **MOUTH & THROAT:**
   - _____ Sore Throat
   - _____ Tonsillitis
   - _____ Mouth Breathing
   - _____ Problems Swallowing
   - _____ Hoarseness

4. **SNORING:**
   - _____ YES
   - _____ NO
   - _____ DAYTIME SLEEPINESS

5. **TABACCO USE:** circle: YES / NO
   IF YES: YEAR STARTED: _____ QUIT: YES / NO WHEN: _____
   CHEW: YES / NO CIGARETTES: YES / NO PACKS/DAY: _____
   PIPE: YES / NO CIGAR: YES / NO

6. **ALCOHOL USE:** circle: YES / NO
   NEVER: _____ DAILY: _____ WEEKLY: _____ SOCIAL: _____
   QUIT: YES / NO WHEN: _____

Reviewed by Employee: _____

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7. **ALLERGIES TO MEDICATIONS:**

_____

_____

8. **MEDICATIONS YOU ARE CURRENTLY TAKING; PLEASE INCLUDE OVER THE COUNTER:**

_____

_____

9. **EARS, NOSE OR THROAT MEDS YOU HAVE TAKEN IN PAST, AND WHY? INCLUDING OVER THE COUNTER.**

_____

_____

10. **DO YOU TAKE BLOOD THINNERS? Circle: YES / NO**

circle: PLAVIX ASPIRIN IBUPROFEN PERSANTINE COUMADIN

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

_____ Diabetes	_____ High Blood Pressure
_____ Hepatitis	_____ Asthma / Lung Problems
_____ Bleeding Tendency	_____ Chest Pain
_____ AIDS / HIV+	_____ Heart Attack / Date: _____
_____ Prev. Ear Surgery	_____ Stroke
_____ Nose / Sinus Surgery	_____ Loud Noise Exposure

11. **Please List Prior Surgeries, including Month & Year:**

_____

_____

12. **Ladies: Could you be Pregnant? YES / NO**

WOULD YOU LIKE DR. DOMB TO KNOW ANYTHING ELSE ABOUT YOU? _____

_____

_____

Reviewed by Employee: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that or relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you . We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION AT ANYTIME, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Patient Preference Regarding Communication of Health Information: Consent to Disclose

I hereby give permission to ***Shasta ENT Specialists*** to disclose and discuss any information related to my medical condition(s) to/with the following member(s), other relative(s) and/or close personal friend(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ NO I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

I wish to be contacted in the following manner:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

- ☐ Ok to leave Message with detailed information
- ☐ Leave Message with call-back number only
- ☐ Written communication: letter / email: _____
- ☐ Ok to Fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Responsible Party Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Shasta ENT Specialists is furnishing you with the attached notice, which provides information about how Shasta ENT Specialists and it's physician(s) may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

_____ _____
Patient or Legal Representative Signature: Date:

Reviewed by Employee: _____

Shasta ENT Specialists
Redding Sinus Center

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PATIENT PORTAL CONSENT FORM: ONLY COMPLETE IF YOU CONSENT TO USE OUR PORTAL.

Patient Name: _____ Date of Birth: _____

Responsible Party: _____

Email Address: _____

Shasta ENT Specialists has a secure website for our patients to communicate with our practice:

- Request Appointments
- Review Health Records
- Message Center / Email Questions
- Review Prescription Refills

You will then receive an email with the Portal link. We recommend saving the website to your favorites before log in. Once you enter your User Name and Temporary Password, you will be prompted to change your password for your security. Save both your User Name & Password for future log ins.

The Portal should NEVER be used for EMERGENCY OR URGENT PROBLEMS.
In the event of an Emergency, call 911 Immediately.

BE CONCISE:
Communication through the Patient Portal should be concise. If your problem is too complex to explain or discuss via simple message. Please request to schedule an appointment through the Portal or call our office at 530.242.5600.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT:

I acknowledge that I have read and fully understand this consent form. All my questions have been answered by the office staff.

_____ _____
Patient / Responsible Party Signature: Date:

Office Use Only:

User Name: _____ Temporary Password: _____

Portal Access Reviewed and Created by: _____ Date: _____

ShastaentsSpecialist

ReddingSinusCenter George H. Domb, M.D.

*Specialized care in Ear, Nose and Throat disorders * Endoscopic Sinus Surgery * Facial Plastic Surgery * Sleep Disorders*

In-Office Nasal Endoscopy Procedures and Insurance

Dear patients:

Please be advised that nasal endoscopies performed at our office are used for both diagnostic and therapeutic purposes. The endoscopies we may employ as part of your nasal and sinus evaluation ensure an accurate and thorough exam.

Depending on the nature of your condition, the endoscopy may be diagnostic and used strictly for visualization purposes. Other times, the scope may be used for surgical purposes to clean an area or remove a polyp or nasal mass.

Insurance companies will consider all these procedures "surgical". We do not have control over how endoscopies are interpreted by insurance companies. Diagnostic endoscopies are always considered "surgical" despite the fact that surgical instruments are not used.

We notify you of this issue in advance, so you are not surprised when you receive an explanation of benefits from your insurance company that states a "surgical service" was provided. Surgical services may also be reimbursed at a different rate than an office visit.

Sincerely,

Shasta ENT Specialists

PATIENT'S SIGNATURE_____ DATE_____

ShastaentSpecialist

ReddingsinusCenter George H. Domb, M.D.

*Specialized care in Ear, Nose and Throat disorders * Endoscopic Sinus Surgery * Facial Plastic Surgery * Sleep Disorders*

Cancellation & No Show Fee Policy

- If you are unable to keep the scheduled appointment, please contact our office to cancel or reschedule 24-48 hours prior so we may fill the appointment.
- We are a referral clinic only and are regularly booked months in advance.
- If a no call or no show occurs, a $50 dollar fee will be applied to your account and an invoice will be mailed to your residential address.
- Until the fee is paid in full, an appointment will not be rescheduled without
- the approval of Dr. Domb and/or the office manager.

Thank you for your understanding and cooperation.

Sincerely,

ShastaENT Specialists

Signature:_____ Date:_____

Phone: 530-242-5600 Fax: 530-242-5605 www.shastaent.net 2125 Court Street, Redding, CA 96001