

TAN HEAD & NECK CENTER
JESUS K. TAN, MD, FACS
JESSE W. TAN, MD, FACS
3530 ATLANTIC AVENUE
SUITE 108
LONG BEACH, CA 90807
PHONE (562) 988-8818 FAX: (562) 988-8819

NEW PATIENT INFORMATION RECORD

PLEASE PRINT LEGIBLY

TODAY'S DATE: _____

PATIENT: _____ BIRTH DATE: _____ AGE: _____ GENDER MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOW DID YOU HEAR ABOUT OUR OFFICE? _____ WHO IS YOUR PRIMARY DOCTOR? _____

NAME OF INSURED PERSON: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

EMAIL ADDRESS: _____ PHONE NUMBER: _____

DRIVER LICENSE: _____ CURRENT EMPLOYER: _____

OCCUPATION: _____ BUSINESS ADDRESS: _____

CITY/STATE: _____ ZIP: _____ BUSINESS PHONE: _____

SOCIAL SECURITY ----- _____

EMERGENCY CONTACTS

1. NAME: _____ RELATIONSHIP: _____ PHONE: _____

2. NAME: _____ RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____ MEDICAL GROUP (IF APPLICABLE): _____

SECONDARY CARRIER: _____ MEDICAL GROUP (IF APPLICABLE): _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Drs. Jesus K. Tan and Jesse W. Tan to disclose when requested by the above named insurance carrier or its representatives any and all information with respect to any illness(es) or injury(ies), medical history or treatment and copies of all medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize payment directly to Drs. Jesus K. Tan and Jesse W. Tan. Of the surgical and/or medical benefits if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment, to bear the cost of reasonable legal fees should this be required.

DATE: _____ PATIENT SIGNATURE (IF MINOR, PARENT SIGNATURE): _____

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MEDICAL HISTORY QUESTIONNAIRE

BRIEFLY, WHAT PROBLEM(S) BRINGS YOU TO OUR OFFICE TODAY?

MEDICAL PROBLEMS (PLEASE CIRCLE IF ANY PERTAIN TO YOU)

HEART DISEASE

DEPRESSION

URINARY RETENTION

HYPERTENTION

ASTHAM

STROKE

HIGH CHOLESTEROL

ALLERGIES

THYROID DISEASE

OTHER _____

PATIENT WITH THYROID/PARATHYROID PROBLEMS: (PLEASE CHECK ANY PERTAINING TO YOU)

_____ FAMILY HISTORY OF THYROID CANCER

_____ FAMILY HISTORY OF HIGH CALCIUM LEVELS

_____ PREVIOUS RADIATION THERAPY/ EXPOSURE

PREVIOUS SURGERIES: _____

DO YOU SMOKE?: Y/N IF SO HOW MANY PACKS A DAY? _____ FOR HOW LONG? _____

DO YOU DRINK ALCOHOL?: Y/N IF SO, HOW MUCH? _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS:

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have the certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certification

***** (A COPY OF THE PRIVACY NOTICE IS POSTED IN THE FRONT OFFICE) *****

I have received, read and understand your NOTICE OF PRIVACY PRACTICE containing more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address about to obtain a current copy of the NOTICE OF PRIVACY PRACTICE.

I understand that I may request in writing that you restrict how my private information is used for disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Tan Head and Neck Center

PATIENT QUESTIONNAIRE

Please mark any symptoms you might be experiencing;

EAR

- Drainage from the ear
- Ear pain
- Hearing loss
- Ringing in the ear
- Dizziness

NOSE

- Nasal obstruction ____ Left ____ Right
- Drainage from the nose
- Nosebleeds
- Facial Pressure
- Post- nasal drip
- Sinus Infections
- If so, how many per year? _____

THROAT

- Difficulty swallowing
- Hoarseness
- Throat Pain

NECK

- Lump in neck
- Neck pain

THYROID/PARATHYROID

- Thyroid nodule
- Needle biopsy of thyroid
- If so, diagnosis? _____
- Family history of thyroid cancer
- History of external beam radiation therapy
- High calcium/parathyroid hormone levels

FACE

- Facial paralysis
- Lesion/mass on face
- History of face/neck skin cancer

LARYNGOSCOPY/NASAL ENDOSCOPY OFFICE PROCEDURES

During your visit, your doctor may need to do additional in-office procedures to properly diagnose and treat your medical problem. These may include the placement of scopes in the nose or throat to obtain a correct diagnosis or treatment. These procedures may be covered by your insurance, or your insurance may require you to pay for a portion or all of such procedures. Any of your potential financial responsibility will be indicated on the explanation of benefits (EOB) that you will receive from your insurance company after your visit.

PHARMACY

Any medication prescribed will be sent to your local pharmacy via computer. Please provide your pharmacy information:

Pharmacy Name: _____

Street Address/Cross Streets: _____

City: _____