Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Tania Edwards, Au.D., CCC
Doctor of Audiology

Simran Kaur, DNP, NP-C
Doctor of Nursing
Blanca Olivia Pena, PA
Physician Assistant

PATIENT INFORMATION

PATIENT NAME Last First M.I		SOCIAL SECURITY NUMBER	
ADDRESS		DATE OF BIRTH	SEX ( ) M ( ) F
CITY STATE ZIP CODE		MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED	
EMAIL	PHONE NO.	ALTERNATE NO.	
PREFERRED PHARMACY NAME	CITY	CROSS STREETS	

EMERGENCY INFORMATION

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NO.

REFERRING INFORMATION

REFERRING DOCTOR	PRIMARY CARE DOCTOR

INSURANCE INFORMATION

PRIMARY INSURANCE		
MEMBER/SUBSCRIBER ID	GROUP NO.	
RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE OF BIRTH
SECONDARY INSURANCE		
MEMBER/SUBSCRIBER ID:	GROUP NO.	
RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE OF BIRTH

I hereby authorize Estrella Ear, Nose and Throat P.C. to release any information in the course of my examination and/or treatment as permitted by law to facilitate treatment, payment, or healthcare. I hereby authorize payment directly to Estrella Ear, Nose and Throat P.C. for surgical and medical benefits. If any, otherwise payable to me under terms of my insurance. I hereby authorize photocopies of this to be valid as the original.
I understand all copays are due at the time of service and I am financially responsible for all non-covered services, insurance denials as well as all services rendered without a referral, if my plan requires a referral for services rendered.
I hereby agree to immediately pay all statements received from Estrella Ear, Nose and Throat P.C. for services rendered.

SIGNATURE ______________________ DATE ______________

Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, DNP, NP-C
Doctor of Nursing
Blanca Olivia Pena, PA
Physician Assistant

Estrella Ear, Nose & Throat Financial Policy

Thank you for choosing Estrella Ear, Nose & Throat. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

1. ____ I understand that if I do not have my insurance card, referral and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments. I further understand that for a deductible of $250 or more, I will be asked to fill out a credit card authorization form in order to process payment once your claim has been posted to your insurance company and the office visit has been applied to your deductible.
2. ____ I understand that if my account is not paid in full, my account will be turned over to a third-party collections company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current.
3. ____ I understand that if I am unable to make a scheduled appointment I need to contact Estrella Ear, Nose & Throat at least ***24 hours*** before my scheduled appointment time. ***An automated reminder call will be made on your behalf and it is necessary that you provide us with a primary phone number from which you check your messages regularly.*** Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent appointments from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENT NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE. If a patient misses 2 visits, Estrella Ear, Nose & Throat reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient notifying you of such a change.
4. **____ It is my responsibility to provide correct insurance information and notify Estrella Ear, Nose & Throat if there is a change in my insurance coverage, residence, or phone number. It is also my responsibility to provide my insurance company with any information that may be requested by them in order to process a claim for services.** If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner, I understand that I will be financially responsible for any and all treatment(s) received. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**

By signing below, I am acknowledging that I have read and understand the above Financial Policy and I agree to abide by its terms.

______________________________	______________________________	____________
Printed Name of Patient	Signature of Patient/Responsible Person	Date

Phone ● 623-535-8770 ● Fax ● 623-535-8771
www.estrellaent.com

Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, DNP, NP-C
Doctor of Nursing
Blanca Olivia Pena, PA
Physician Assistant

Please complete the following:

You have my consent to leave messages with family members or significant others and/or on my answering machine. YES ________ NO ________

You have my consent to discuss my medical treatment/condition with the following:

____

Name Relationship

____

Name Relationship

____

Name Relationship

Assignment & Release

I also authorize the release of any information required to process insurance claims, including any information relating to alcohol, drug abuse, and/or AIDS. I authorize release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and others involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at any time.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of Estrella Ear, Nose and Throat may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure or referral and that I have the option to decline such treatment or seek further information.

______________________________________ ______________________________

Patient Signature or Signature of Parent/Guardian Date

______________________________________ ______________________________

Patient Name (if patient is a minor) Relationship to Patient

Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, DNP, NP-C
Doctor of Nursing
Blanca Olivia Pena, PA
Physician Assistant

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________ acknowledge that I have been offered a copy of
(Name of Patient)

ESTRELLA EAR, NOSE, AND THROAT **"Notice of Privacy Practices".** This notice describes how ESTRELLA EAR, NOSE, AND THROAT may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_______________________________________ ____________________

Signature of Patient, or Personal Representative Date

____

Relationship to Patient

HIPAA-ACK2

Phone ● 623-535-8770 ● Fax ● 623-535-8771
www.estrellaent.com

Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Alan Brenner, MD
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, DNP, NP-C
Doctor of Nursing
Blanca Olivia Pena, PA
Physician Assistant

Patient Name: ______________________________________ **DOB:** ________________ **Date:** ______________

LATEX ALLERGY? ☐ Yes ☐ No

If yes, what type of reaction? ____

ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No

If yes, please list.

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No   Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No   How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

FAMILY HISTORY:

ADD/ADHD ☐ **Yes**
Alcoholism ☐ **Yes**
Allergies ☐ **Yes**
Alzheimer's Disease ☐ **Yes**
Asthma ☐ **Yes**
Blood disease ☐ **Yes**
CAD (Coronary Artery Disease) ☐ **Yes**
Cancer Type: ______________ ☐ **Yes**
CVA (Stroke) ☐ **Yes**
Depression ☐ **Yes**
Developmental delay ☐ **Yes**
Diabetes ☐ **Yes**
Hearing deficiency ☐ **Yes**
Hyperlipidemia ☐ **Yes**
Hypertension ☐ **Yes**
Mental illness ☐ **Yes**
Migraines ☐ **Yes**
Obesity ☐ **Yes**
Osteoarthritis ☐ **Yes**
Osteoporosis ☐ **Yes**
PVD ☐ **Yes**
Renal disease ☐ **Yes**
Seizure disorder ☐ **Yes**
Other: ________________________________

SOCIAL HISTORY:

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**

Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** ______________________________ **Amount per day?** ___________

SURGICAL HISTORY:

List *ANY and ALL* surgeries/procedures you have had done.

______________________________ ______________________________

______________________________ ______________________________

HOSPITALIZATIONS

List any hospitalizations & the facility you were hospitalized at within the last year

______________________________ ______________________________

______________________________ ______________________________

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

☐ **No Past Medical History**

Cardiovascular:		**Year Diagnosed**
Coronary Artery Disease	☐ **Yes**	________
Elevated cholesterol (hyperlipidemia)	☐ **Yes**	________
High Blood Pressure (hypertension)	☐ **Yes**	________
Other	☐ **Yes**	________
Gastrointestinal:		
Hepatitis	☐ **Yes**	________
Hernia	☐ **Yes**	________
Gastroesophageal Reflux	☐ **Yes**	________
Other	☐ **Yes**	________
Genitourinary:		
Prostate enlargement (Prostatitis)	☐ **Yes**	________
Kidney Stones (Nephrolithiasis)	☐ **Yes**	________
Acute Renal Failure	☐ **Yes**	________
Other	☐ **Yes**	________
Infectious Disease:		
Mononucleosis	☐ **Yes**	________
STD Type: ________	☐ **Yes**	________
Other	☐ **Yes**	________
Metabolic/endocrine:		
Diabetes	☐ **Yes**	________
Thyroid deficiency (hypothyroidism)	☐ **Yes**	________
Thyroid excess (hyperthyroidism)	☐ **Yes**	________
Thyroid mass	☐ **Yes**	________
Other	☐ **Yes**	________
Neoplastic:		
Cancer Type: ________	☐ **Yes**	________
Treatment	☐ **Yes**	________
Treatment Type:	Chemo	Radiation Surgery
Other	☐ **Yes**	________
Neurologic:		
Migraine	☐ **Yes**	________
CVA (stroke)	☐ **Yes**	________
Seizures	☐ **Yes**	________
Alzheimer's Disease	☐ **Yes**	________
Other	☐ **Yes**	________
Obstetric:		
Pregnancy(s) #________	☐ **Yes**	________

Ear / Nose / Throat: (ENT)		**Year Diagnosed**
Cataracts	☐ **Yes**	________
Glaucoma	☐ **Yes**	________
Chronic ear infections (otitis media)	☐ **Yes**	________
Hearing loss	☐ **Yes**	________
Sinus problems (chronic sinusitis)	☐ **Yes**	________
Nasal polyps	☐ **Yes**	________
Nasal allergies	☐ **Yes**	________
Recurrent tonsillitis	☐ **Yes**	________
Tinnitus	☐ **Yes**	________
Vertigo	☐ **Yes**	________
Other	☐ **Yes**	________
Hematologic :		
Anemia	☐ **Yes**	________
Other	☐ **Yes**	________
Immunologic:		
Allergies Type: ________	☐ **Yes**	________
Food Allergies Type: ________	☐ **Yes**	________
HIV / AIDS	☐ **Yes**	________
Other	☐ **Yes**	________
Psychiatric:		
Anxiety	☐ **Yes**	________
Depression	☐ **Yes**	________
Other	☐ **Yes**	________
Pulmonary:		
Asthma	☐ **Yes**	________
COPD/Emphysema	☐ **Yes**	________
Sleep Apnea	☐ **Yes**	________
CPAP	☐ **Yes**	________
Tuberculosis	☐ **Yes**	________
Other	☐ **Yes**	________
Miscellaneous:		
Anesthesia Reaction	☐ **Yes**	________
Other	☐ **Yes**	________
Miscellaneous PEDIATRIC:		
Complications during Pregnancy	☐ **Yes**	________
Complications during Delivery	☐ **Yes**	________
Failed newborn hearing screening	☐ **Yes**	________
NICU stay >48hrs:________	☐ **Yes**	________
Preterm birth	☐ **Yes**	________
Other	☐ **Yes**	________

REVIEW OF SYSTEMS: Check any of the following problems you have recently had:

General health problems
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐weight gain ☐sleeping problems

Eye problems
☐blurred vision ☐double vision ☐itching ☐eye pain ☐redness ☐swelling

Ear problems
☐hearing loss ☐ear pain ☐dizziness ☐ringing/noise in ears ☐ears feel pressured ☐discharge/drainage from ears
☐ear infections ☐itchy ☐noise exposure

Nose & Sinus problems
☐nose bleeds ☐chronic congestion ☐nose/sinus problems ☐runny nose ☐sinus pressure

Mouth & Throat problems
☐sore throat ☐snoring ☐dry mouth ☐sores in mouth ☐ulcers ☐difficulty swallowing ☐post nasal drip
☐hoarseness ☐ mouth breathing

Brain or Nervous system problems
☐fainting ☐frequent headaches ☐seizures ☐numbness ☐migraines ☐loss of consciousness
☐facial pain ☐weakness

Heart or circulation problems
☐chest pain ☐heart murmur ☐irregular heart beat ☐light-headed upon standing ☐swelling of ankles ☐blacking out

Lung or respiratory problems
☐wheezing ☐shortness of breath ☐ cough ☐ sleep apnea

Stomach problems
☐vomiting ☐heartburn ☐painful swallowing ☐no appetite ☐increased appetite ☐abdominal pain
☐diarrhea ☐nausea

Blood or Lymph node problems
☐swollen glands ☐bruises easily ☐bleeds excessively after injury ☐enlarged lymph nodes

Muscle problems
☐muscle aches ☐joint pain ☐leg cramping

Skin
☐rash ☐itchy ☐dry skin ☐growth/lesions ☐swelling ☐urticaria / hives

Glands & Hormone problems
☐increased thirst ☐increased appetite ☐intolerance to heat ☐intolerance to cold ☐neck enlargement

Allergy problems
☐frequent sneezing ☐runny nose
☐food intolerances ☐insect bites ☐other ____

What is the reason you are here today? ____

____

____

Responsible Party Signature: ______________________________ **Date:** ______________