



ENT Center of Excellence

*Board Certified Surgeons specializing in all aspects of
medical and surgical needs pertaining to the EAR, NOSE & THROAT.*

Gary A. Buxa, MD, FACS

Richard T. Bergstrom, MD

Last Name, First, Middle Initial			Employers Name		
Social Security Number			Full Time Part Time Unemployed Disabled Student Homemaker Retired Self		
Date of Birth	Sex M F	Marital Status M D S W	Work Phone	Occupation	
Mailing Address			Work Address		
City	State	Zip Code	Emergency Contact		
Home Phone	Cell Phone		Emergency Contact Phone	Relationship	
IF PATIENT IS A MINOR —NAME OF RESPONSIBLE PARTY					
RELATIONSHIP TO MINOR					
May we leave messages on voice mails? YES NO					

INSURANCE INFORMATION: (if you are going to "SELF PAY" check here and skip this section)

Primary Insurance		Secondary Insurance	
Policy or ID Number		Policy or ID Number	
Group Number		Group Number	
Subscribers Name	Relationship to Patient	Subscribers Name	Relationship to Patient
Subscribers Social Security #	Subscribers Date of Birth	Subscribers Social Security #	Subscribers Date of Birth
Subscribers Employer		Subscribers Employer	

Please list your primary care physician and any other physician who may have referred you to us:

	Name	Address	Phone Number
Primary Care Physician	_____		
Referring Physician	_____		

HAVE YOU SEEN ONE OF OUR DOCTORS IN THE PAST? ____ IF SO, WHEN? _____

**PLEASE CONTACT OUR OFFICE 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE AN APPOINTMENT.
THERE WILL BE A \$50.00 CHARGE FOR MISSED APPOINTMENTS.**

I consent to treatment and authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

PATIENT, PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

3305 Placer Street, Suite A • Redding, CA 96001
Office: 530.243.ENTS (3687) • Fax: 530.243.3383 • www.ENTexcellence.com

Reviewed By: _____



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Authorization for Use or Disclosure of Health Information

Patient Name: _____
(print)

Patient's Date of Birth: _____

I authorize ENT CENTER OF EXCELLENCE, DR. RICHARD BERGSTROM AND DR. GARY BUXA to release information or records about me to:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Authorized Information will be used and/or disclosed for the following purposes:

- At the request of the individual (check the box if applicable)
- Other (Please list each purpose of the use(s) or disclosure(s) in the space provided):

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying ENT CENTER OF EXCELLENCE in writing. However, if I choose to do so, I understand that my revocation will not affect any actions take by ENT CENTER OF EXCELLENCE before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I understand that ENT CENTER OF EXCELLENCE may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that ENT CENTER OF EXCELLENCE will not provide such research –related treatment unless I provide this authorization. NOTE: If this provision is applicable, the third party for whom the information is being created must be listed under “Person or Class of Person to Whom the Use or Disclosure of Authorized Information May be Made.” Also, the purpose for which the information is to be created and disclosed must be listed under “Authorized Information will be Used or Disclosed for the Following Purposes.”

This authorization expires on the following date _____ OR the date the following event occurs (whichever is earlier):

(describe event or write “not applicable”)

I am the individual to whom the information/record applies to or that person's parent (if a minor) or legal guardian.

Signature: _____

Date: _____ Relationship: _____

Patient & Family History

Patient Name: _____ Age: _____ DOB: _____ Today's Date: _____

Who referred you to our office: _____ Primary Care Physician _____

Reason for this visit: _____

Please be as accurate and complete as possible. This information will assist the Doctor in your treatment.

Medical Illness's:

	Yes	No		Yes	No
Cardiac Disease (heart attack, heart disease)	___	___	Glaucoma	___	___
Cardiologist name: _____			Osteoporosis	___	___
High Blood Pressure	___	___	Other: _____		
Kidney Disease	___	___	_____		
Convulsion Disorder (epilepsy)	___	___	_____		
Chronic Lung Disease	___	___	_____		
Diabetes	___	___	_____		
A Bleeding Tendency	___	___	_____		

Past Surgeries:

Current Medications:

Please indicate if none () List of medications attached ()

Known allergies to medications:

Please indicate if none ()

Family Medical History:

Please indicate if none ()

Cancer _____ Diabetes _____ Heart disease _____ TB _____ Other _____

Social History:

Occupation _____ Employer _____ Marital Status _____

Do you use Tobacco? Yes ___ No ___ Daily amount used? _____ How many years? _____

Do you use Alcohol? Yes ___ No ___ Daily amount used? _____ Caffeine use? Yes ___ No ___

Are you pregnant? Yes ___ No ___ illicit drug use? _____

Review of Systems - Please circle if you have or have had any of the following:

<u>Constitutional</u>	Appetite change	Weight chg	Fever	Chills	Fatigue	None
<u>Skin</u>	Itching	Rash	Hives	Skin cancer	None	
<u>Allergy/Imm.</u>	Food	Seasonal	None			
<u>ENM&T</u>	Hearing changes	Ear pain	Ringling	Voice Changes	None	
<u>Eyes/Head</u>	Vision changes	Headaches	Dizziness	None		
<u>Respiratory</u>	Shortness of Breath	Cough	Wheezing	None		
<u>CV</u>	Leg swelling	Irregular heart beat		None		
<u>GI</u>	Indigestion/heartburn	Nausea	Bowel changes	Pain/difficulty swallowing		None
<u>GU</u>	Painful urination	Blood in urine	Decreased flow	Frequent night urination		None
<u>Endo</u>	Diabetes	Steroid use	Thyroid problems	None		
<u>Musculoskeletal</u>	Joint pain	Muscle pain	Gout	Osteoporosis	None	
<u>Neuro</u>	Seizure	Stroke	Tingling	None		
<u>Psych</u>	Anxious	Depressed	Stress	None		
<u>Heme/Lymph</u>	Anemia	Bruise easily	Bleeding	Swollen glands	None	

All other systems _____

Indicate if you use the back of the form or attach additional medical information ()

Do not write below this line. For office use only!

Reviewed by Doctor: _____ Date: _____



PATIENT NOTIFICATION DISCLOSURE OF PHYSICIAN OWNERSHIP

We would like to disclose to you that the physicians have a financial interest in the following healthcare facilities:

**Apogee Outpatient Surgery Center
North State Surgery Centers**

You have the right to use a healthcare facility other than those listed, if you choose. You will not be treated differently by your physician if you choose another health care facility.

If you have any questions concerning this notice, please feel free to ask for additional information from your physician or a representative of ENT Center of Excellence.

If you are uncomfortable with your physician's relationship with any of these healthcare facilities and prefer to have your surgery performed elsewhere, we will be happy to honor your request. Please do not hesitate to talk to us about scheduling your surgery at another healthcare facility.

I have read and understand this Disclosure of Physician Ownership.

Patient or Responsible Party Signature

Date

Patient Name – Please print



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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of **Buxa & Bergstrom ENT Center of Excellence** Notice of Privacy Practices.

Signature of Patient

Date

FOR OFFICE USE ONLY

- Consent received by _____
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____