REDDING E.N.T. HEAD AND NECK SURGERY, INC.
JORY N. KAPLAN, M.D., F.A.C.S.
DIPLOMATE
AMERICAN BOARD OF OTOLARYNGOLOGY
Serving the Northstate Since 1992

Welcome to Redding E.N.T. !

In order to give you the best care we can give,
and to help Dr. Kaplan run on time
you will need to:

return this paperwork with a copy of your insurance card as soon as possible. You can bring in your insurance card into our office to make a copy, or arrive 15 minutes early for us to make a copy and enter your information.

You can either

mail it back to :
Redding E.N.T.
2143 Airpark Drive
Redding, CA 96001

or Fax it to:
(530) 241-8798

or Drop it off at our office

We strive to give you the best care we can give.
In order to do that it starts with getting
your information entered prior to your appointment.

If we do not receive this paperwork before your appointment, we will have to reschedule your appointment.

Thank you,
and we look forward to seeing you.

REDDING E.N.T. HEAD AND NECK SURGERY, INC.

JORY N. KAPLAN, M.D., F.A.C.S. *Serving the Northstate Since 1992*
DIPLOMATE
AMERICAN BOARD OF OTOLARYNGOLOGY
Phone# (530) 241-8799
Fax# (530) 241-8798

Welcome to Our Office!

Dear _____:

Your new patient appointment is _____ at _____ a.m./p.m. Dr. Kaplan and his staff would like to take this opportunity to welcome you to Redding E.N.T. Head & Neck Surgery, Inc. We look forward to being a part of your healthcare. Dr. Kaplan, along with his staff, is committed to treatment being successful and to making our relationship a positive one.

As a courtesy, we will bill your insurance company (primary and secondary), providing you give us your current insurance information and patient information sheet with current address and telephone number. Please fill out the enclosed patient information sheet completely. Once you have completed this packet we need it returned to our office at least a week or two prior to your appointment. You can mail, fax, or drop off at our office. Please bring with you to your appointment:

- All insurance and prescription cards and/or numbers;
- Radiology reports (x-ray, CTs, MRIs, etc.), including films;
- If faxing to us, please bring the attached "original" new patient information forms;
- ER reports, if applicable.

NOTE: **We need to receive your completed paperwork at least a week (or two) prior to your appointment. The deadline to return this packet is 2 business days prior to your appointment. If you forget to mail (or fax) your paperwork to us within this timeframe, we will need to cancel your appointment. Thank you for your cooperation in helping us give you the best care possible.**

***** You should receive a confirmation call prior to your appointment. If you **cannot** keep this appointment, please call **48 hours** before the scheduled time. WE RESERVE THE RIGHT TO CHARGE UP TO $50.00 FOR PATIENTS THAT "NO SHOW" THEIR APPOINTMENTS. Thank you for choosing Redding E.N.T. Head & Neck Surgery, Inc., as your head and neck care specialist. We look forward to serving your needs in the future.

If there are any questions, please contact our office at 241-8799.

Sincerely,
REDDING E.N.T. HEAD & NECK SURGERY, INC.

REDDING E.N.T. HEAD AND NECK SURGERY, INC.

Jory N. Kaplan, M.D., F.A.C.S.
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WELCOME TO OUR OFFICE

TODAY'S DATE:_____

Thank you for choosing our office. In order to serve you properly, we will need the following information. PLEASE PRINT LEGIBLY. All information will be kept strictly confidential.

PATIENT'S NAME:_____

PATIENT'S SOCIAL SECURITY #:_____

MARITAL STATUS: S M W ☐ Male ☐ Female **DATE OF BIRTH**:_____

MAILING ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

E-MAIL ADDRESS:_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL PHONE:**_____

CAN WE TEXT YOU APPOINTMENT REMINDER? ☐ **YES** ☐ **NO**

PARENT OR SPOUSE'S NAME:_____

ADDRESS & PHONE (only if different from above):_____

_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT: ☐ Self ☐ Other

SOCIAL SECURITY # OF RESPONSIBLE PARTY:_____

EMPLOYER OF RESPONSIBLE PARTY:_____

OCCUPATION:_____ **BUSINESS PHONE**:_____

DO YOU HAVE MEDICAL INSURANCE? ☐ YES ☐ NO

PRIMARY INSURANCE COMPANY:_____

SECONDARY INSURANCE COMPANY:_____

PRESCRIPTION COVERAGE:_____

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU:_____

RELATIONSHIP TO PATIENT:_____ **PHONE**:_____

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.

SIGNATURE:_____

(Patient, Parent or Legal Guardian)

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Today's Date: _____

Patient Name: _____

Date of Birth: _____

Name of Referring Doctor: _____ City/State _____

Reason for Visit: _____

Name of Primary Care Physician: _____ City/State _____

Preferred Pharmacy : _____ Street Address: _____

Past Medical History

Any Significant illnesses? If so, please list: _____

_____

Surgical History:

Procedure Date Physician

_____

_____

_____

_____

Social History:

Smoker? __ Yes __ No __ Former (Date Quit: _____/No of Packs: _____)
Number of Packs per Day: _____ Number of Years: _____
Chew Tobacco? __Yes __No __ Former (Date Quit: _____)

Drink Alcohol? __Yes __No __Former
Type of Alcohol: __Beer __Wine __Liquor
Number of Drinks: _____ per __Day __Week __Month __Year

Drug Use? __Yes __No __Former
Drug Type(s): _____

Current Medical Conditions: Are you currently experiencing any of the following symptoms?

Ear/Nose/Throat:
- Earache
- Ear Discharge
- Nosebleeds
- Tinnitus(ringing in ears)
- Hearing Loss
- Nasal Congestion
- Sore Throat
- Hoarseness
- Dysphagia (difficulty swallowing)
- Snoring
- Mouth Breathing
- Runny Nose
- Postnasal Drip
- Polyps
- Problems with Smell
- Tonsillitis

General Health:
- Fatigue
- Sleepiness
- Sleep Problems
- Weight Loss
- Malaise (feeling unwell)

Respiratory:
- Wheezing
- Dyspnea
- Excessive Sputum
- Cough

Neurolgic:
- Headaches
- Syncope (fainting)
- Vertigo

Have you had a Audiogram in the past year? ☐ **No** ☐ **Yes**

Vital Signs: Height: _____ Weight: _____

Medication Allergies: ☐**No** ☐**Yes**

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Are you taking any blood thinners? ☐**No** ☐**Yes**

Medications: (PLEASE COMPLETE ALL INFORMAITON) You may attach a separate page if necessary

Medicine	**Strength**	**Dosing**

REDDING E.N.T. HEAD AND NECK SURGERY, INC.

Jory N. Kaplan, M.D., F.A.C.S.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, REDDING ENT HEAD AND NECK SURGERY, INC., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for 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 who 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 that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that REDDING ENT HEAD AND NECK SURGERY, INC., is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. I also understand that by refusing to sign this consent or revoking this consent, REDDING ENT HEAD AND NECK SURGERY, INC., may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that REDDING ENT HEAD AND NECK SURGERY, INC., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should REDDING ENT HEATH AND NECK SURGERY, INC. change their notice, they will send a copy of any revised notice to the address I have provided, whether by U.S. mail or, if I agree, e-mail.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Date: _____ Patient/Guardian Signature: _____

CANCELLATION / NO SHOW POLICY

We adhere to a strict cancellation/no show policy. Patients are responsible for notifying the office of any appointment cancellations at least 48 hours prior to their scheduled appointment. The patient may be responsible for the Doctor's and Nurse's fees for any no-shows or cancellations that occur within 48 business hours of their scheduled appointment. For example, cancellations must be made by 10AM Friday for a 10AM Monday appointment. **Weekends and holidays are NOT considered business days.**

The staff of Redding ENT Head & Neck Surgery will attempt to fill an appointment cancelled with 48 hours, but the patient **may be billed $50.00 for the total amount of time that could not be rescheduled.** We withhold the right to rescind the cancellation/no show fees on a case-by-case basis (as in such instances of emergencies or acts of nature).

I have read and understand Redding ENT Cancellation/no-show policy. **I understand I am responsible for giving Redding ENT adequate notice of a cancellation to my scheduled appointment.**

Date: _____ Patient/Guardian Signature: _____

Directions to Redding E.N.T.

2143 AIRPARK DRIVE
REDDING, CA 96001

1. Head West on **44 Freeway**, when you arrive to downtown Redding it will turn into **Shasta Street.**
2. Stay on **Shasta Street**
3. Turn left of **Court Street**
4. Take the 4th right on **Placer Street**
5. Turn left on **Airpark Drive**
6. After you pass Gold Street, Turn left into the **Escorial Complex.** Our building is the first building on the left. Located at **2143 Airpark Drive**