

Pacific Eye and Ear ° Pacific Head and Neck Pacific Cosmetic Surgeons ° Pacific Hearing and Balance SPECIALISTS

Alyssa Ba MD, PhD

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Adults and Children

Cadvan O. Griffiths MD, LLB

Cosmetic & Reconstructive Surgery
Medical Legal Consultant

Chester F. Griffiths MD, FACS

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Cosmetic & Reconstructive Surgery
Adults and Children

Howard R. Krauss, MD

Ophthalmology
Neuro-Ophthalmology
Orbital Surgery
Adult Strabismus
Oculoplastic Surgery
Laser Vision Correction

William W. Lee, MD FACS

Ear, Nose & Throat
Head and Neck Surgery
In Consultation

Jeremy E. Levenson, MD

Ophthalmology
Cornea/External Disease of Eye
Cataract Surgery

Dorothy Wang, MD

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Adults and Children

Gregory J. Frazer AuD, PhD

Julie Skille AuD, F-AAA

Kathy Harlan MA CCC-A

Audiology
Balance Testing/Therapy
Hearing Aids
Children and Adults

Welcome To Our Practice

We are very happy to welcome you to our multi-subspecialty office and surgical center. We appreciate the chance to take care of you and your family. Our office is focused on providing you with high quality care with a friendly and welcoming staff to assist you.

Enclosed you will find a health history form, a patient registration form, our financial policy and directions to our office location. Please complete the enclosed forms and bring them with you on your first appointment.

Please note:

We have three locations to help serve you: Brentwood, Malibu and Marina del Rey. We also would like you to be aware of the other services we are able to offer to our patients:

Laser Services

- Hair Removal
- Photofacial
- Vein Removal
- Micro Laser Peel
- Skin Resurfacing
- Photodynamic Acne/Rocacea Therapy

Hearing & Balance

- Hearing Tests
- Vestibular/Balance Testing
- State of the Art Hearing Aids
- *Featuring the world's FIRST invisible Hearing Aid, The Lyric!*

Cosmetic Procedures

- Blepharoplasty (Eyelid)
- Rhinoplasty
- Otoplasty (Ear revision)
- Brow Lift
- Chin, Cheek and Facial Implants
- Breast Augmentation/Reduction
- Abdominoplasty (Tummy Tuck)
- Liposuction
- BOTOX
- Restylane Injections
- Radiesse Injections
- Juvaderm Injections
- Physician ONLY Skin Care Products

Ear, Nose & Throat

- Pillar (Snoring Procedure)
- Sinus Surgery
- Tonsillectomy w/ Coblation
- Skin Cancers

Ophthalmology

- LASIK
- Implantable Contact Lenses
- Refractive & Cataract Surgery
- Thyroid Eye Disease
- Orbital Surgery
- Contact lenses

Please visit our websites for directions and more information:
www.PacificSpecialists.com and www.PacificCosmeticSurgeons.com.

Thank you for choosing our office, we look forward to meeting you.

Sincerely,

The Doctors and Staff of Pacific Specialists

11645 Wilshire Boulevard - Suite 600 - Los Angeles, CA 90025 - Tel 310.477.5558 - Fax 310.477.7281
4644 Lincoln Boulevard - Suite 400 - Marina del Rey - CA 90292 - Tel 310.574.1116 - Fax 310.574.1126
www.PacificSpecialists.com www.PacificCosmeticSurgeons.com

An Association, not a Group Practice

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Date: _____

ACCT.#: _____

To ensure proper communication with your doctor, please provide an email address.

PATIENTS PERSONAL INFORMATION

Marital status Single Married Divorced Widowed Age (edad) _____ Sex F M
(estado civil)

Name: _____
Last Name (apellido) First Name (primer nombre) Middle Initial

How do you wish to be addressed? _____ Email: _____
(correo electrónico)

Street address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
(domicilio) (ciudad) (estado) (zona postal)

Home phone: (_____) _____ Work phone: (_____) _____ Mobile phone: (_____) _____
(teléfono de casa) (teléfono de trabajo) (teléfono de celular)

Date of Birth: ____/____/____ Driver's license (State): _____ Social Security#: _____
(fecha de nacimiento) (licencia de conducir) (número de seguro social)

Spouse or parent's name (if minor): _____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Self Spouse Other

Responsible party's home phone: (_____) _____ Work phone: (_____) _____

Address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
(domicilio) (ciudad) (estado) (zona postal)

Employer's name: _____ Phone number: (_____) _____
(nombre de trabajo/compañía) (teléfono de trabajo)

Your occupation: _____
(nombre de empleo)

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name: _____

Name of insured: _____ Date of birth: _____

Relationship to insured: Self Spouse Child Other

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Name of insured _____ Date of birth: _____

Relationship to insured: Self Spouse Child Other

Insurance ID number: _____ Group number: _____

PATIENTS REFERAL INFORMATION

Referred by: _____ Phone: _____
(referencia, médico quien lo/la recomendó?) (teléfono de doctor)

EMERGENCY CONTACT

Name of a person not living with you: _____
(NAME ONLY, contacto de emergencia)

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (_____) _____

I hereby acknowledge that a copy of the Pacific Specialists Notice of Privacy Practices was made available to me.

Signature _____

Date _____

Signature (firma) _____

Print Name (en letra de molde) _____

Date (fecha) _____

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ADULT SHEET

PATIENT NAME _____ AGE _____ DATE _____

What is the reason for your visit today? _____

• Please list all medications you currently take with the dose and times per day: ** This includes herbal, vitamins and all non-prescription products and supplements.* _____

• Do you take Aspirin/Advil on a regular basis? YES NO Diet Pills? YES NO How Long? _____

MEDICATION ALLERGIES: 1. _____ 2. _____ 3. _____

OTHER ALLERGIES: 1. _____ 2. _____ 3. _____

**Please write additional information on the back*

• Are you currently pregnant? YES NO Are you currently on a Contraceptive medication program? YES NO

PAST MEDICAL HISTORY (type and date): **Please write additional information on the back*

Hospitalizations: 1. _____ 2. _____ 3. _____
Operations: 1. _____ 2. _____ 3. _____
Illnesses: 1. _____ 2. _____ 3. _____
Injuries/Fractures 1. _____ 2. _____ 3. _____

SOCIAL HISTORY:

• Smoke: YES NO _____ packs per day • Drugs: YES NO _____ type/amount • Caffeine: YES NO _____ cups per day
• Alcohol: YES NO _____ type/amount • Diet: _____ type

FAMILY HISTORY (check any that apply):

Asthma Diabetes High Blood Pressure Thyroid Disease Hearing Loss
 Allergies Cancer Tuberculosis Dizziness (vertigo) Heart Disease
 Bleeding Problems Stroke Autoimmune Disease Headaches Eye Problems

HAS ANYONE IN THE FAMILY HAD AN UNFAVORABLE REACTION TO ANESTHESIA? YES NO

Please Explain _____

REVIEW OF SYSTEMS (check any that apply):

EARS:	<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Exposure to Loud Noise	<input type="checkbox"/> Pain <input type="checkbox"/> Tinnitus (noise in ears)	<input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Discharge	<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Surgery: _____
NOSE:	<input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Snoring	<input type="checkbox"/> Stuffiness <input type="checkbox"/> Nasal Sprays	<input type="checkbox"/> Bleeding <input type="checkbox"/> Injuries	<input type="checkbox"/> Change in Smell <input type="checkbox"/> Surgery: _____ <input type="checkbox"/> Post Nasal Drip
THROAT:	<input type="checkbox"/> Soreness <input type="checkbox"/> Bad Taste <input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Pain or Difficulty Swallowing <input type="checkbox"/> Recent Dental Work <input type="checkbox"/> Voice Change/Hoarseness	<input type="checkbox"/> Tonsillitis <input type="checkbox"/> Bad Breath <input type="checkbox"/> Lump	<input type="checkbox"/> Cough <input type="checkbox"/> Reflux <input type="checkbox"/> Surgery: _____
NECK:	<input type="checkbox"/> Lumps <input type="checkbox"/> Pain	<input type="checkbox"/> Thyroid Nodules <input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Injuries <input type="checkbox"/> Surgery: _____	
EYES:	<input type="checkbox"/> Loss/Blurred Vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Eye Disease	<input type="checkbox"/> Double Vision <input type="checkbox"/> Itching, Burning, Irritation <input type="checkbox"/> Floating Objects in Vision <input type="checkbox"/> Cataracts	<input type="checkbox"/> Injuries <input type="checkbox"/> Eye Pain/Soreness <input type="checkbox"/> Dryness of Eyes <input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Excess Tearing <input type="checkbox"/> Redness/Inflammation <input type="checkbox"/> Glaucoma <input type="checkbox"/> Surgery: _____

PERSONAL HISTORY:

Anemia Chronis Lung Disease Emphysema Hepatitis or Paralysis Shortness Of Breath
 Angina/Chest Pain Constipation Headaches Jaundice Prostate Problems Stroke
 Anxiety Colitis Heart Failure/Attack Kidney Disease Psoriasis Tuberculosis
 Asthma Diabetes Heartburn Kidney Stones Psychiatric Ulcers
 Arrhythmia Diarrhea High Blood Pressure Liver Disease Rashes Vaginitis
 Bleeding Problems Difficulty Urinating Autoimmune Disease Lyme Disease Rheumatic Fever Weight Loss or Gain
 Cancer Eczema Pain w/ Urination Sexual Dysfunction

Is there anything else about your medical history that might be helpful for the doctor to know? _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE : _____ DATE: _____

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SUPPLEMENTAL REGISTRATION INFORMATION

Full name and address of referring physician: _____

Telephone number: _____

Full name and address of general physician/internist: _____

Full names and addressed of other physicians you wish to receive reports: _____

Telephone number: _____

DATE

PATIENTS SIGNATURE

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Financial and Payment Policy For Medical Services

Insurance

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to insure all plan requirements are met.

_____initial

Cancelled Appointments

Charges may be made for broken, confirmed appointments and appointments cancelled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs medical care. Failure to show up for a scheduled confirmed appointment may result in a \$50 cancellation fee.

_____initial

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand however, that: **WE ARE NOT PREFERRED PROVIDERS FOR ANY INSURANCE PLANS. AS A COURTESY, WE WILL BILL YOUR INSURANCE BUT YOU ARE RESPONSIBLE FOR THE PORTION OF THE BILL THAT IS UNPAID.** Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure that our fees are consistent with the charges in the geographic region. Your insurance company may not use "reasonable charge information" specific to this region and specialties in this office. In fact, many carriers purchase non-specific data and/or do not update their information on an annual basis. Some reputable insurance companies consider our fees usual, customary, and reasonable. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is the patient's responsibility and duty to have an understanding of the benefits and eligibility, stipulated under their individual insurance policy. We will contact your insurance carrier to verify coverage information prior to rendering Surgical Services ONLY.

We must emphasize that as medical care providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

_____initial

Payment for Services

Payment for services is due at the time services are rendered if: you do not have insurance, are a Blue Shield or Blue Cross Individual Provider member, or are receiving cosmetic treatments. We accept cash, personal checks, cashier's checks, money orders, Visa and Mastercard. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

_____initial

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Thank you.

My Signature below constitutes acknowledgement and acceptance of this policy.

Signed Patient or Guarantor

Print

Date

Witness

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Directions and Parking

West Los Angeles/Brentwood (Home Office)
TEL: 310.477.5558 • FAX: 310.477.7281

Brentwood
11645 Wilshire Blvd. 6th Floor
Los Angeles, CA 90025

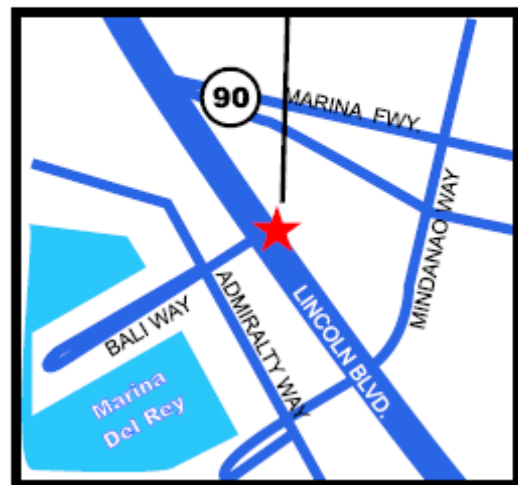


We have the whole 6th floor at 11645 Wilshire Blvd.
between Federal and Barrington, on the corner of Barry.

PARKING: The building has parking below the complex at a rate of \$2.25 per 15 minutes, with a maximum of \$17.00 (Anything longer than 2 hours). Unfortunately, we only validate for patients having surgery at our Surgery Center. Limited metered street parking is available on Barry and the surrounding streets. Please be sure to read all posted signs and fill the meter.

Marina del Rey Office:
TEL: 310.574.1116 • FAX: 310.477.7281

Marina del Rey
4644 Lincoln Blvd #400
Marina del Rey, CA 90292



PARKING: The Marina del Rey office shares parking with Daniel Freeman Hospital. Please enter the parking structure off Lincoln. (Please note, you can only enter the parking lot when traveling North on Lincoln.) It is \$1.50 every 20 minutes with a maximum of \$8.00. Limited street parking is available but be sure to read all posted signs