

Pacific Eye and Ear ° Pacific Head and Neck Pacific Cosmetic Surgeons ° Pacific Hearing and Balance S P E C I A L I S T S

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 also be sure to bring your insurance card.

Please note: we are out of network for all insurance companies and you will be responsible for payment at the time of your visit. The amount will depend on the treatment you receive but will be between \$190-\$580. We will provide a copy of your bill for you to submit to your insurance company for reimbursement. If you have Medicare, we will bill this for you and you will only be responsible for a refraction fee of \$50, if we provide this service to you as well as deductibles or co-pays, if not covered by your secondary insurance.

We also would like you to be aware of the over services we are able to offer to our patients:

Laser Services

- Hair Removal
- Photofacial
- Vein Removal
- Micro Laser Peel
- Skin Resurfacing
- Photodynamic Acne/Rosacea 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
- Juvederm 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

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

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

Marni L. Novick, AuD, CCC-A

Audiology
Balance Testing/Therapy
Hearing Aids
Children and Adults

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Chester F. Griffiths MD FACS • Cadvan O. Griffiths MD • Howard R. Krauss MD • Jeremy E. Levenson MD • William W. Lee MD, FACS
Michelle A. Putnam MD • Rinaldo Canalis, MD • Gregory J. Frazer AuD, PhD • Marni L. Novick AuD CCC-A

Date: _____

ACCT.#: _____

Please print and complete ALL sections below

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

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): _____

How do you wish to be addressed? _____

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: _____ Email: _____
(nombre de empleo) (correo electrónico)

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 person not living with you: _____ Relationship: _____
(NAME ONLY, contacto de emergencia)

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

Phone number (home): (_____) _____

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

PERSONAL HISTORY:

Anemia Chronic 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 or referring physician: _____

Telephone number: _____

Full name and address of general physician/internist: _____

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

Telephone number: _____

DATE

PATIENTS SIGNATURE

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INFORMATION REGARDING DILATION OF THE PUPILS

I understand that if I receive drops for dilation of the pupils in the course of my evaluation or treatment today, there may be a period of eye discomfort, sensitivity to bright light or visual impairment lasting several hours.

I understand that dilating drops will not be instilled in my eyes without my permission.

I further understand that it is my responsibility to determine the safest mode of travel following my departure from the office and that some people experience discomfort or difficulty with driving following dilated examination of the eyes.

I understand that I may be examined or treated in the office today without undergoing dilation and that I will be informed of the nature of drops used today prior to their instillation.

Patient Signature

Date

Witness

Date

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Dear Patient,

Medicare and most insurance plans do not cover the prescribing of glasses. Therefore, at those times when a prescription for glasses is required, we have found it necessary to request the \$50 refraction fee from patients. Please feel free to discuss this with us should you have any questions.

Patient Signature

Date

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ASSIGNMENT OF BENEFITS

I hereby assign to **Howard R. Krauss MD/ Jeremy E. Levenson MD** (Provider) all of my rights, title, interest in and to any and all health care and/or surgical benefits, otherwise payable to me for medical treatment including emergency medical services if rendered. In absence of such payment, Provider is furthered assigned all necessary rights to enforce collection of such payments or benefits, including the right to file a lawsuit or demand arbitration directly against the insurer, plan or payer.

I further agree that I am financially responsible for charges not collected by this Agreement. I authorize the provider to contact the employer and/or company responsible for the payment of any benefits for the purpose of determining the existence and extent of benefits, and I authorize the release of any and all information in possession of the employer and/or company necessary to determine the existence and/or extent of such benefits.

For and in consideration of services rendered, I agree that this Provider shall have an irrevocable lien, equal to the charges for the services rendered on any recovery due the patient because of the injury or illness required this Provider's services, whether said recovery is by judgment, settlement, arbitration award, hearing award, compensation, or insurance payment.

Patient Name (Print)

Patient Signature

Date

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of patient
- beneficiary or personal representative of deceased patient
- spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

I acknowledge that I am still responsible for paying the above referenced physician if the relevant insurer plan or payer does not pay the physician in full.

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I certify that I am not a member of any Health Maintenance Organization (HMO) or Private Fee for Service Plan. For example: Kaiser; United Health Plan (UHP); Family Health Plan (FHP); Medicare Advantage or any such program. I further understand that membership in such a program prevents Medicare or any Private Insurance Company from covering my expenses for services provided by Dr. Howard Krauss/Dr. Jeremy Levenson and that I would be fully responsible for those uncovered charges.

Patient Signature

Date

Witness

Date

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

“I request that payment of the authorized Medicare and/or other insurance benefits be paid on my behalf to Howard R. Krauss, M.D./ Jeremy Levenson, M.D. for any services furnished me by that physician. I authorize the holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.”

Patient Signature

Date

Witness

Date

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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



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

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



We have the whole 6th floor in the City of Hope building, between Federal and Barrington, on the corner of Barry.

PARKING: The City of Hope Building has parking below the complex at a rate of \$2.25 for the first 60 minutes with a maximum of \$15.75 (Anything longer than 1.5 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.

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

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