

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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Dorothy Wang, 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 REFERRAL 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"/> Stiffness	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Change in Smell <input type="checkbox"/> Post Nasal Drip
	<input type="checkbox"/> Snoring	<input type="checkbox"/> Nasal Sprays	<input type="checkbox"/> Injuries	<input type="checkbox"/> Surgery: _____
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 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 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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Directions and Parking

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

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

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

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 street at a rate of \$2.25 for the first 60 minutes with a maximum of 1.5 hours. Unfortunately, we only validate parking for patients having surgery at our Surgery Center. Limited meter 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 Freeman Hospital. Please enter the parking structure off Lincoln Blvd. (Please note, you can only enter the parking lot when traveling south on Lincoln.) It is \$1.50 every 20 minutes with a maximum of 1.5 hours. Limited street parking is available but be sure to read all posted signs.