Dr. James Yee-*PATIENT REGISTRATION*

Todays Date_____

Name:

_____

First **Middle** **Last**

Date of Birth: _____ **Male/ Female** **SSN** _____-____-_____

mm/dd/yyyy

Address:_____

Street **City** **State** **Zip**

Home Phone: (_____) _____ **Cell Phone:** (_____)_____

Employer: _____ **Work Phone:** (_____) _____

Email: _____

Emergency contact: _____ _____ (_____)_____

Race_____**Ethnicity**_____**Nationality**_____**language**_____

Marital status: Single___ Married___ Divorced___ Widowed___ Cohabitating___

Current Occupation: _____ **Disabled___ Retired___ Student___**

Insurance Information

Insurance name:
Insurance ID :
Group or Policy Number:
Policy Holders Name:

Primary Care Physician _____ **Referring Physician**_____

Medicare/Medi-Cal Lifetime Signature on File*:*

I request that payment of authorized Medicare/Medi-Cal benefits be made on my behalf to Dr. James Yee, Inc. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable to related services. I understand that I am financially responsible to James Yee, M.D. until my bill is paid in full.

Signature of Beneficiary: _____ Date:_____

Patient Declaration:

I hereby authorize payment directly to James Yee, M.D. 1600 Creekside Drive, Ste 3400, Folsom, CA 95630 (916)984-1234 of all insurance benefits, including major medical, herein specified and otherwise payable to me, for services rendered by James Yee, M.D. Payment for care rendered by James Yee, M.D. as an inpatient in the hospital is also assigned as shown above. I understand that I am financially responsible to James Yee, M.D. until my bill is paid in full. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Signature **Date**

What is the reason for your visit today?_____

How tall are you? _____ How much do you weigh? _____

List all current medications, including any over the counter (OTC) medications or supplements ☐ **Not taking any medications**

Name of Medication and Dosage

List any drug allergies or medicines you cannot take ☐ **No known drug allergies**

Name of Medication	Type of Reaction

Do you have allergies to the following; if so please specify:

Food Y N _____

Environmental Y N_____

Have you had any of the following surgeries:

tonsil and/or Adenoid_____Ear_____Nose/Sinus_____Throat/Neck_____

Pharmacy_____

Past Medical History *Please check any that apply*

Ear		Nose		Throat		Other		Other	
Hearing Loss		Sinus Infections		Sore throat		Stroke		Lungs	
Ear Infections		Nasal Pain		Sleep Apnea		Hypertension		Headache	
Ear Ringing/ Itching		Nasal Congestion		snoring		Thyroid Dysfunction		TMJ Dysfunction	
Ear Pain		Thyroid Disease		Mouth sores		Reflux		Cancer	
Ear Wax		Nasal Drainage		Enlarged Tonsils		Depression		Bruise Easily	

Family History

Please list any of your BLOOD RELATIVES who have a history of any of the following and give their relationship to you: ☐ **Family history unknown**

	RELATIONSHIP
Problems/Complications with Anesthesia	**No Yes _____**
Heart Problems (Including Hypertension)	**No Yes _____**
Lungs	**No Yes _____**
Bleeding/Clotting Problems	**No Yes _____**
Glands/Hormones (Diabetes)	**No Yes _____**
Cancer	**No Yes _____**

Social History

Current Occupation: _____ Disabled___ Retired___ Student___

Tobacco use?
Never____ Yes: Cigarette____ Cigar___ Pipe___ Chew____

***When did you start?* Age: _____or Year: _____**
***Average use per day* _____**

Quit
***When did you stop?* Age:_____or Year:_____**

***Alcohol use?* No____ Yes____**

***Types & average number per week?* Beer: ____ Wine: ____ Wine Coolers: ____ Mixed Drinks or Liquor ____**
Have you ever been dependent on or addicted to any drugs?
No___Yes _____ Prefer to discuss with doctor

Review of Symptoms-please check mark to any symptoms you have, or may have had recently.

Constitutional		**Throat/Mouth**		**Dermatologic**	
Fever		Change in Smell		Rash	
Weight Gain		Change in taste		Skin Change	
Weight Loss		Drooling		New Lesion	
		Dysphagia		**Neurologic**	
Eyes		Dry Mouth		Brain Injury	
Blurred Vision		Halitosis		Confusion	
Eye Pain		Hoarseness		Dizziness	
Vision Loss		Jaw Pain		Headache	
		Mouth Sores		**Psychiatric**	
Ears		Sore Throat		Depression	
Ear Pain		Voice Change		Anxiety	
Ear Drainage		**Cardiovascular**		**Endocrine**	
Hearing Loss		Irregular Heart Beat		Cold Intolerance	
Ear Plugging		Chest Pain		Heat Intolerance	
Ear Itchy		Chest Pressure			
Tinnitus		Lightheadedness		**Hematologic**	
Vertigo		**Respiratory**		Swelling	
		Short of Breath		Easy Bruising	
Nose		Cough		Easy Bleeding	
Epistaxis		Wheezing			
Nasal Congestion		**Gastrointestinal**		**Allergy**	
Nasal Drainage		Abdominal Pain		Cough	
Nasal Pain		Heart Burn		Excessive Tearing	
Postnasal Drip		Nausea		Eye Itching	
Sinusitus		**Musculoskeletal**		Eye Redness	
Sneezing		Painful Joints		Hives	
Snoring		Muscle Weakness		Nasal Drainage	
		Stiffness		Sneezing	

I AUTHORIZE JAMES YEE, M.D. TO OBTAIN AND/OR RELEASE MY MEDICAL RECORDS FOR THE PURPOSE OF MEDICAL TREATMENT.

_____ _____

Signature **Date**

James Yee M.D.

Privacy consent form:

James Yee M.D. recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own records. (Protected health Information)

With my consent James Yee M.D. may use and disclose any Protected Health Information (PHI) about myself, or my child, to carry out treatment, payment, or to collect any outstanding charges, and healthcare operations. Please refer to James Yee M. D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices prior to signing this consent. Our office reserves the right to revise our notice of Privacy Practices at any time.

With my consent, this office may mail to my home or other designated location, or leave a message on voicemail, or in person in reference to any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminders, insurance items payment items, and any call pertaining to my clinical care, including laboratory results and information among others.

With my consent, James Yee M.D. office may mail to my home and other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminder cards, patient statements, and any other information regarding my, or my child's healthcare.

With my consent, James Yee M.D. restricts how it uses, and discloses my healthcare information to carry out treatment and payment. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing the form, I am authorizing James Yee M. D. to use and disclose my PHI to carry out treatment, payment, and other health care operations.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

The Doctor may release PHI to: Spouse____Partner____Guardian____Other_____