

**Nina J. Lee-Tall, M.D, Inc.**

Otolaryngology Head and Neck Surgery  
Adult and Pediatric Ear Nose and Throat  
23456 Hawthorne Blvd. Suite 290  
Torrance, CA 90505  
Phone: (310) 375-2102  
Fax: (310) 791-6319

**PATIENT'S INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ SEX: M/F

BIRTH DATE: / / MARITAL STATUS: \_\_\_\_\_ DRIVER'S LIC#: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (CELL): \_\_\_\_\_ (WORK): \_\_\_\_\_

Which is the best number to contact you during business hours? \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PARENT (IF UNDER AGE 18): \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ (Name of a friend/relative not living at same address)

PHONE: \_\_\_\_\_ CELL/WORK: \_\_\_\_\_ RELATION: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DO WE HAVE PERMISSION TO:**

- Leave a message on your answering machine? Yes/No (Circle)
- Leave a message on your cell phone? Yes/No (Circle)
- Leave a message at work? Yes/No (Circle)
- Discuss your medical condition with anyone? Yes/No (Circle)
- If yes, please give name(s): \_\_\_\_\_

**BILLING INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S BIRTH DATE: / /

RELATION TO SUBSCRIBER (CIRCLE): SELF / SPOUSE / CHILD / OTHER

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Dr. Nina Lee-Tall, M.D., or my insurance company to release any information required to process my claim.

**MEDICARE**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. If I only have Medicare I will be responsible for whatever Medicare does not cover. This includes (United Healthcare, TriCare as secondary) since we have NO contract with these insurances.

PATIENT/ GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you currently have, or history of:**

Ear disease: \_\_\_\_\_

Nose/Sinus disease: \_\_\_\_\_

Throat/Mouth disease: \_\_\_\_\_

**Do you currently have, or history of:**

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Seizure             | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Major trauma: type _____     |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer: type _____           |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Lung disease: type _____     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Heart disease: type _____    |
| <input type="checkbox"/> Autoimmune disease  |                                    | <input type="checkbox"/> Thyroid disease: type _____  |
| <input type="checkbox"/> Bleeding disorder   |                                    | <input type="checkbox"/> Severe allergies: type _____ |
| <input type="checkbox"/> Liver disease       |                                    | <input type="checkbox"/> Kidney disease               |

**Please note any medical problems you have been treated for, not listed above:**

\_\_\_\_\_  
\_\_\_\_\_

**Past surgical history: (Please list your operations and year performed)**

\_\_\_\_\_  
\_\_\_\_\_

**Medications you are currently taking (prescription or over the counter):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications:**

**Family history of medical problems:**

\_\_\_\_\_  
\_\_\_\_\_

**Do you have currently or a history of:**

- |  |                  |                      |
|--|------------------|----------------------|
| <input type="checkbox"/> Smoking/tobacco use | Amount/day _____ | If quit, date: _____ |
| <input type="checkbox"/> Alcohol use         | Amount/day _____ | If quit, date: _____ |
| <input type="checkbox"/> Drug use            | Amount/day _____ | If quit, date: _____ |

**Patient/Guardian signature:** \_\_\_\_\_

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**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review and receive a copy of our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

With my consent, Nina J. Lee-Tall, M.D. and staff may call my home or other designated location \_\_\_\_\_ and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Nina J. Lee-Tall, M.D. and staff may e-mail or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and advertisements for our services.

I have the right to request that Nina J. Lee-Tall, M.D. and staff restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if does, it is bound the agreement.

By signing this form, you consent to use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, sign by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

If I do not sign this consent, Nina J. Lee-Tall, M.D. and staff may decline to provide treatment to me.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and I have had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing with a verifiable signature on file, at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name of Guardian

\_\_\_\_\_  
Witnessed By:

Please list any relatives or friends we may release your health information to, should they inquire about it:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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To improve efficiency in the office, and to better serve patients, the following policies will be instituted:

**(Please read and initial the following items)**

\_\_\_\_\_ It is your responsibility to inform my staff of any insurance changes. My staff will make every effort to verify eligibility and coverage at the time of your visit. If we are unable to do so, you will be required to pay for the visit at the time of service. You will be responsible for billing your insurance for that date of service, should you wish to be reimbursed.

\_\_\_\_\_ It is imperative that my staff has your current address and phone number. Please notify us of any changes.

\_\_\_\_\_ Co-payments are due at the time of service. There is a \$5 service charge for the non-payment at the time of service.

\_\_\_\_\_ There is a \$20 charge for all returned checks. Repeat occurrences will result in a "cash only" policy.

\_\_\_\_\_ Statements are sent monthly. If your account is over 90 days delinquent you will be seen on a "cash only" basis. You will be required to pay your balance prior to future medical services.

\_\_\_\_\_ Cancellation policy: As a courtesy, my staff will call to remind you of a visit one day in advance. All "no-shows" are charged \$50. This \$50 charge is not billable to your insurance company. Patients with multiple late cancellations (day of appointment) will be charged \$50.

\_\_\_\_\_ Late Policy: We respect your time and make every effort to see you at your scheduled appointment time. In turn, we expect you to arrive on time. When you arrive 20 minutes past your appointment you have missed your appointment and you will need to reschedule.

\_\_\_\_\_ In accordance with the laws of the State of California, I do NOT prescribe medication for patients over the phone for a new illness. A visit must be scheduled.

\_\_\_\_\_ Three "no show" appointments will result in our office asking you to transfer medical care to another physician.

Patient(s) Name \_\_\_\_\_

I have read, understand, and agree to the above stated policies.

Patient/Parent Signature \_\_\_\_\_

Date \_\_\_\_\_