

OCEANN ENT

Dr. Kathy Yu-Syken, MD

Please Print Clearly

First Name _____ Middle Initial _____ Last Name _____

Date Of Birth ____/____/____ SSN ____-____-____ Age _____ Gender M / F

Address _____ City _____ State _____ Zip _____

Home: (____) _____ Cell: (____) _____ Email: _____

Primary Physician _____ Address _____

Employer _____ Occupation _____ Work (____) _____

How did you hear about us? (*Circle one*)

Google _____ Yelp _____ Internet _____ Referral _____ Other _____

Guarantor

First Name _____ Middle Initial _____ Last Name _____

Date Of Birth ____/____/____ SSN ____-____-____ Age _____ Gender M / F

Address _____ City _____ State _____ Zip _____

Home: (____) _____ Cell: (____) _____ Relationship to Patient: _____

Insurance Information

Primary

Secondary

Subscriber _____

Subscriber _____

Insurance Company _____

Insurance Company _____

ID # _____

ID # _____

Group # _____

Group # _____

I hereby assign my insurance benefits to be paid directly to Dr. Kathy Yu-Syken. It is understood that in case the patient's insurance company does not make payment, the obligation shall be binding personally upon the patient/ guarantor.

Signature _____

Date _____

Please Print Clearly

Reason for Visit _____

Duration of Symptoms _____

Pharmacy Name _____ City _____ Phone (____) _____

Medications (Including Over the Counter)

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoke YES NO (Please circle one)

Allergies to Medication? YES NO (Please circle one) If yes, please list below

_____ Reaction: _____	_____ Reaction: _____
_____ Reaction: _____	_____ Reaction: _____
_____ Reaction: _____	_____ Reaction: _____

Medical History

Surgeries	Year	Surgeries	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Illness

I.D.: _____

SINO-NASAL OUTCOME TEST (SNOT-22)

DATE: _____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5	<input type="radio"/>
2. Nasal Blockage	0	1	2	3	4	5	<input type="radio"/>
3. Sneezing	0	1	2	3	4	5	<input type="radio"/>
4. Runny nose	0	1	2	3	4	5	<input type="radio"/>
5. Cough	0	1	2	3	4	5	<input type="radio"/>
6. Post-nasal discharge	0	1	2	3	4	5	<input type="radio"/>
7. Thick nasal discharge	0	1	2	3	4	5	<input type="radio"/>
8. Ear fullness	0	1	2	3	4	5	<input type="radio"/>
9. Dizziness	0	1	2	3	4	5	<input type="radio"/>
10. Ear pain	0	1	2	3	4	5	<input type="radio"/>
11. Facial pain/pressure	0	1	2	3	4	5	<input type="radio"/>
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5	<input type="radio"/>
13. Difficulty falling asleep	0	1	2	3	4	5	<input type="radio"/>
14. Wake up at night	0	1	2	3	4	5	<input type="radio"/>
15. Lack of a good night's sleep	0	1	2	3	4	5	<input type="radio"/>
16. Wake up tired	0	1	2	3	4	5	<input type="radio"/>
17. Fatigue	0	1	2	3	4	5	<input type="radio"/>
18. Reduced productivity	0	1	2	3	4	5	<input type="radio"/>
19. Reduced concentration	0	1	2	3	4	5	<input type="radio"/>
20. Frustrated/restless/irritable	0	1	2	3	4	5	<input type="radio"/>
21. Sad	0	1	2	3	4	5	<input type="radio"/>
22. Embarrassed	0	1	2	3	4	5	<input type="radio"/>

2. Please mark the most important items affecting your health (maximum of 5 items) _____ ↑



Eustachian Tube Dysfunction Patient Questionnaire (ETDQ-7)¹

Name: _____ Date: _____

Next to each question, circle the number that best describes how you feel.

During the past 1 month, how much of a problem was each of the following?	No Problem		Moderate Problem		Severe Problem	
1. Pressure in the ears?	1	2	3	4	5	6 7
2. Pain in the ears?	1	2	3	4	5	6 7
3. A feeling that your ears are clogged or "under water"?	1	2	3	4	5	6 7
4. Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6 7
5. Crackling or popping sounds in the ears?	1	2	3	4	5	6 7
6. Ringing in the ears?	1	2	3	4	5	6 7
7. A feeling that your hearing is muffled?	1	2	3	4	5	6 7

Do you get these symptoms in one ear only or both ears?

☐ Left ear only ☐ Right ear only ☐ Both ears

Total Score _____ $\div 7 =$ **Mean item score** _____



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice reserves the right to change the privacy policy as allowed by law.
- The Practice has the right to restrict the use of information, but the Practice does not have to agree to those restrictions.
- The Practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: (*PRINT NAME PLEASE*) _____

Signature: _____

Date: _____

Witness: _____

Date: _____