

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 _____

City _____ State _____ Zip _____ Phone(____) _____

Employer _____ Work(____) _____

Address _____ City _____ State _____ Zip _____

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 _____

Pharmacy Name _____ City _____ Phone(____) _____

Medications (Including Over the Counter)

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

Smoke YES NO

Allergies to Medication YES NO

Medical History

Surgeries

Illnesses



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/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 the information but the practice does not have to agree to those restrictions.
- The patient 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: _____

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 checked="" type="radio"/>
2. Nasal Blockage	0	1	2	3	4	5	<input type="radio"/>
3. Sneezing	0	1	2	3	4	5	<input checked="" 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 checked="" type="radio"/>
8. Ear fullness	0	1	2	3	4	5	<input type="radio"/>
9. Dizziness	0	1	2	3	4	5	<input checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/>
20. Frustrated/restless/irritable	0	1	2	3	4	5	<input type="radio"/>
21. Sad	0	1	2	3	4	5	<input checked="" 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) _____ ↑