ENTNORTHWEST
EAR | NOSE | THROAT

Jared C Hiebert, MD

Welcome!

We would like to take this opportunity to welcome you to our clinic and thank you for choosing Ear, Nose and Throat Northwest for your health care needs. We look forward to providing you with quality care and service.

In order to be respectful of the medical needs of our patients, please be courteous and call at least 24 hours prior to your appointment if you are unable to attend. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all our patients.

Please complete the enclosed registration forms and return them to the front desk on your appointment date. Also, please remember to bring your **current insurance cards and photo identification.** If the patient is a child under 18 years old, please bring photo identification of parent or legal guardian. If child is less than 18 years old, a parent or guardian **must** accompany them at the first visit.

Co-payments and/or deductibles are **required** at time of service and will be collected prior to your appointment with our physicians. We accept cash, checks, Visa, Mastercard, Discover and American Express.

If you have a managed care insurance that requires prior authorization, it is your responsibility to obtain a referral from your Primary Care Physician.

If you have any questions regarding our clinic or your scheduled appointment, please call our office at (503) 980-1950. Thank you very much.

Ear, Nose and Throat Northwest, LLC

_____ has an appointment scheduled on

_____ at _____.

(Please arrive 20 minutes before your scheduled appointment time)

Office Address:

2025 Madrona Ave SE, Suite 100
Salem, OR 97302

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PATIENT INFORMATION

Patient Name: (First, MI, Last) _____ Sex: [ ] M [ ] F

Birth Date: _____ Age: _____ SS#: _____ Email: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Employment Status: [ ] Full [ ] Part [ ] Student [ ] Retired [ ] None Employer Name: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Decline

Is your condition a result of a work Injury? [ ] Yes [ ] No Date: _____ Auto Accident? [ ] Yes [ ] No Date: _____

Preferred Pharmacy: _____

REFERRAL INFORMATION

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____ Relation: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____ Relation: _____

ALL PATIENTS PLEASE READ AND SIGN THE STATEMENT BELOW

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of ENT Northwest. All co-payments are due at the time of service as stated in your insurance contract. If your insurance carrier requires a referral you will need to have that in place before your appointment. If self-pay, payment is due at time of service. If payment plans are needed, please consult the business office. Your signature below indicates that you understand and accept this policy and acknowledge that you are financially responsible for all charges not covered by insurance. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance/Medicare claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____

Signature of patient or legal guardian Date

2025 Madrona Ave SE, STE 100
Salem, OR 97302

T: (503)-980-1950
F: (877)-610-3876

info@entnorthwest.com

www.entnorthwest.com

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IF THE PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THIS SECTION:

Legal Guardian/Parent Name: _____

Relationship to Patient: _____

Legal Guardian Birth Date: _____

Address, if different than Patients: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

PARENT CONTINUE IF THE PATIENT IS NOT 15 YEARS OF AGE OR OLDER. IF PATIENT IS 15 YEARS OF AGE OR OLDER, HE/SHE WILL COMPELTE THE FOLLOWING:

Does Ear, Nose and Throat Northwest have your permission to:

- Leave a message on your voicemail/answering machine?

  [ ] Yes [ ] No

- May we discuss your medical condition with other members of your household?

  [ ] Yes [ ] No

  If yes, please give the name of that person: _____

  What is that person's relationship to you? _____ Phone Number:_____

_____

Signature of patient (if 15 years of age or older) Date

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Pediatric Health History

Patient Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Doctor you are seeing today: _____

How did you hear about our practice? _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F

What is the primary reason for your child's visit with the doctor today? _____

_____

Does your child have a:

Latex Allergy ☐ Yes ☐ No

Drug Allergy ☐ Yes ☐ No

If yes, please list medications and reactions: _____

_____

Medications

Please list any medications that your child takes on a regular basis. Include medication name, dose, and frequency.

_____

_____

Past Medical History

Does your child have any medical problems? ☐ Yes ☐ No

Please list: _____

_____

_____

_____

Has your child ever had cancer? ☐ Yes ☐ No

If so, what type? _____

Past Surgical History

Has your child ever had surgery? ☐ Yes ☐ No

Please list type and approximate date: _____

_____

_____

Social History for Children:
Who is the primary caregiver of your child (mother, father, grandparent, etc.)?

_____

Does your child attend daycare? ☐ Yes ☐ No
Does anyone smoke around your child? ☐ Yes ☐ No
Have immunizations been updated? ☐ Yes ☐ No
When? _____
Does your child have siblings? ☐ Yes ☐ No
Age(s) _____

Health problems of siblings: _____

_____

_____

Family History: Any family history of the following? If yes, please list relation to the child:

Heart Disease	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Bleeding tendencies	☐ Yes	☐ No	_____
Other _____			_____

Review of Systems: Does the child currently have any of the following symptoms?

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Lethargy	☐ Yes	☐ No
Weight gain/loss	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No

Hematological/Lymphatic

Blood clotting problem	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Swollen nodes	☐ Yes	☐ No
History of a transfusion	☐ Yes	☐ No
History of Hepatitis	☐ Yes	☐ No

Allergic/Immunologic

Itchy eyes/nose	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Pets in the home	☐ Yes	☐ No
Immune disorder	☐ Yes	☐ No

Does your child have:

Trouble sleeping	☐ Yes	☐ No	Tonsil infections	☐ Yes	☐ No
Frequent awaking	☐ Yes	☐ No	How many per year?	_____	
Snoring	☐ Yes	☐ No	Ear infections	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No	How many per year?	_____	
Restless legs	☐ Yes	☐ No	Trouble hearing	☐ Yes	☐ No
Sleep walking	☐ Yes	☐ No	How long?	_____	
Sleep talking	☐ Yes	☐ No	Speech difficulty	☐ Yes	☐ No
Wetting the bed	☐ Yes	☐ No	Reflux	☐ Yes	☐ No
Trouble eating	☐ Yes	☐ No	Large tonsils	☐ Yes	☐ No
Finicky eating habits	☐ Yes	☐ No	Failure to thrive	☐ Yes	☐ No
Sinus infections	☐ Yes	☐ No			
How many per year?	_____				

Pharmacy you prefer to use: _____

Location: _____

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APPOINTMENT CANCELLATION/NO SHOW POLICY FOR ENT NORTHWEST

ENT Northwest is privileged to provide medical and surgical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

CLINIC APPOINTMENT CANCELLATION POLICY

Any patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance of their appointment may be subject to a $25 fee.

We understand that delays can happen; however, in fairness to other patients, if you arrive more than 15 minutes after your scheduled appointment, we may have to reschedule your appointment to another day.

If an established patient fails to keep three appointments, or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

SURGERY CANCELLATION/NO SHOW POLICY

Please consider your surgical date carefully before scheduling. Your surgery requires the coordination of several providers, including the surgeon, anesthesiologist, facility and possibly a pathologist. Therefore, any surgery that is cancelled less than seven days prior to the surgery will be subject to a $75 fee. Patients who fail to check in for surgery or who give less than 24-hour notice of cancellation will be subject to a $150 fee.

FEES

All fees charged by ENT Northwest pursuant to this No Show/Cancellation policy are not payable by your insurance company.

Your physician may waive your "no-show" fee for good cause shown. To request that this fee be waived, you must email a written request and explanation to the following address: info@entnorthwest.com

Thank you for your consideration and understanding of our policy.

_____

I have read and understand the above policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient/ Guardian Date

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