SENTA CLINIC

PERRY MANSFIELD M.D. INC
REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (Check one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ website ❑ Internet Search

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary Insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Perry Mansfield M.D. Inc or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

SENTA CLINIC

PERRY MANSFIELD MD INC

Patient Name: (LAST, FIRST, MIDDLE) _____Date:_____

Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes ☐	No ☐
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes ☐	No ☐
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes ☐	No ☐
Do you have or are you being treated for high blood **P**RESSURE?	Yes ☐	No ☐

BANG		
BMI more than 35kg/m2?	Yes ☐	No ☐
AGE over 50 years old?	Yes ☐	No ☐
NECK circumference > 16 inches (40cm)?	Yes ☐	No ☐
GENDER: Male?	Yes ☐	No ☐

TOTAL SCORE	0	

High risk of OSA: **Yes 5 – 8**

Intermediate risk of OSA: **Yes 3 – 4**

Low risk of OSA: **Yes 0 - 2**

SENTA CLINIC
DIVISION OF OTOLARYNGOLOGY/ HEAD AND NECK SURGERY

PERRY T. MANSFIELD, MD, FRCSC
Director of Skull Base Surgery &
Head and Neck Oncology

Head and Neck Oncology
Skull Base Surgery
Sleep Apnea Surgery

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.
Note: *Information and records regarding treatment of minors, HIV, psychiatric/ mental health conditions, or alcohol/ substance abuse have special rules that require specific authorization.*

AUTHORIZATION:

I hereby authorize: _____
Physician/ Healthcare Facility

To release information on _____ (patient's name) _____ (DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records including those from my other health care provider that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Dr. Perry Mansfield
Name
3590 Camino Del Rio North Suite 100
Address
San Diego CA 92108
City State Zip code

The medical information/ records will be used for the following purpose: _____

This authorization is:
[X] Unlimited (all records, excluding Substance Abuse, Mental Illness, HIV Diagnosis/ Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/ Substance Abuse _____(initial) HIV Diagnosis/ Treatment_____(initial)
Psychiatric/ Mental Health _____(initial) Genetic Information _____(initial)
Test for Antibodies to HIV _____(initial)

DURATION: This authorization shall be effective immediately and remain in effect until canceled in writting

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/ personal Representative patient* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

NEUROSURGERY
Sanjay Ghosh, MD
Scott P. Leary, MD
Jeffrey Schweitzer, MD
Vikram Udani, MD
Amanda W Gumbert, PA-C
Felix Regala, PA-C
Ashley Ryan, PA-C

OTOLARYNGOLOGY/
HEAD & NECK SURGERY
Perry T. Mansfield, MD
Michael J. O'Leary, MD
Brian H. Weeks, MD
Jeffrey Lin, PA-C
Jeannine Shively, PA-C

PLASIC SURGERY
Jason D. Toranto MD
,
NEUROLOGY
Ian M. Purcell, MD, PhD

LOCATIONS

LA JOLLA
9850 Genesse Ave
XiMED Building Suite 650
La Jolla, CA 92037

ALVARADO
6645 Alvarado Rd
SDRI, Suite 4000
San Diego, CA 92120

KEARNY MESA
3939 Ruffin Road
San Diego, CA 92123

MESA COLLEGE
7625 Mesa College Drive
Suite 305A
San Diego, CA 92111

**CORPORATE &
MAILING ADDRESS**

**MISSION VALLEY
3590 Camino Del Rio N
Suite 100
San Diego, CA 92108**

**PH: 619-810-1111
FX: 619-229-4938**

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BROKEN APPOINTMENTS POLICY

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. We currently have a waiting list for appointments and when you give us advance notice of appointment changes, this helps us accommodate other patients. We appreciate your consideration.

Please read and sign our policy as indicated below:

BROKEN APPOINTMENTS POLICY:

PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDLED APPOINTMENTS WITHOUT PRIOR NOTIFATION TO OUR OFFICE MAY BE CHARGED A FEE OF $50.

- This "broken appointment" fee is NOT RECOVERABLE from your insurance plans and will be charged to the patient.
- Repeated "broken appointments" may negatively impact your healthcare and result in notification to your referring physician of disengagement from our practice. Please be kind enough to call in advance, preferably 24 hours in advance if you need to cancel or reschedule an appointment.

Thank you for your assistance and courtesy towards other patients:

_____
Patient Name (Print)

I have read and agree to the "Broken Appointment" Policy.

_____ _____
Patient or Legal Guardian Signature Date

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Financial Policy

We cannot guarantee your benefits or eligibility with your insurance plan. Your insurance plan is a contract between you and your insurance company.

Upon completion of our patient Registration Form and your Assignment of Benefits, we will extend the benefit offered by your insurance company and file for reimbursement. We will handle the necessary insurance filing paper work for you. All payments are expected at the time of visits for services not covered by your insurance plan.

If your insurance company pays only a portion of the bill or denies the claim, an explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of the financial obligation. We will notify you if this occurs and we will request payment in full.

I have read the above and I understand and agree to the Perry T. Mansfield, M.D., Inc. Financial Policy. I authorize the release of any medical information necessary to process insurance claims and to comply with medical reviews and audits. I further authorize payment of my benefits be made to Perry T. Mansfield, M.D., Inc. for services provided to me. I understand that the ultimate responsibility for payment of services remains mine.

_____ _____
Print Name of Patient or Responsible Party Date

_____
Signature of Patient or Responsible Party

*A Copy of this signature is valid as the original

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Skull Base Surgery
Sleep Apnea Surgery

Senta CT scanner/ ChEARS Audiology/ Amerisleep Diagnostics/ E-Prescribe

In the circumstance that Dr. Mansfield determines that you require further radiology or audiology evaluation or are in need of a Sleep Study and recommends that you have this preformed at Senta Imaging, LLC or ChEARS Audiology or Amerisleep Diagnostics, please be aware that he has financial interest in the aforementioned entities. There are other facilities available in our community where the same procedure(s) can be performed, and you do have the option to use one of these alternates. You will not be treated any differently regardless of the entity you choose to be treated. If you have any questions regarding this, please feel free to contract our office at (619) 810-1111. We do electronic prescribing and require your written consent for viewing your Rx history.

_____

Patient Name (Please print)

I have read and agree to the above and understand that Dr. Mansfield has a financial interest in the aforementioned entities.

_____ _____

Patient Signature/ *Legal Guardian* Date

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Acknowledgement of Receipt of Notice of Privacy Practices
Perry T. Mansfield, M.D.

I hereby acknowledg that I received a copy of this Notice of Privacy Practice. I furhter acknowledge that a copy of the current notice will be posted in the reception area.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

E-mail address: _____

Signature: _____ **Date:** _____

Patients Name: _____

Date of Birth: _____ **Phone Number:** _____

If not signed by patient, please indicate:

Relationship:

☐ Parent of Guardian of minor patient.

☐ Guardian or Conservator of an incompetent patient.

☐ Beneficiary or personal representative of deceased patient

Patient Name: _____ **Date:** _____

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