Christina M. McAlpin M.D.
F.A.C.S.
Otolaryngology - Ear, Nose & Throat Surgery

1513 S Grand Ave #310, Los Angeles CA 90015
Tel: (213) 745-4060 Fax: (213) 279-9924
www.cmcalpinmd.com

REGISTRATION FORM

(Please Print)

Today's Date:			Primary Care Physician		
PATIENT INFORMATION					
Patient's last name: First: Middle:			☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	Social Security No.	Birth Date: / /	Age:	Sex: ☐M ☐F
Street Address:			Home Phone: ( )	Mobile phone: ( )	
City:	State:		Zip Code:		
Email Address:					
Occupation:	Employer:		Employer phone no. ( )		
I was referred to this clinic by (please check one box): ☐Dr. ☐ Insurance Plan ☐Hospital ☐Family ☐Friend ☐Close to home / work ☐Yellow Pages ☐Other					
Other family members seen here:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no. ( )	Cell 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 an balance. I also authorize Christina M Mcalpin, M.D. or insurance company to release any information required to process claims.

Patient / Guardian Signature Date

Christina M. McAlpin M.D.
FACS
Otolaryngology - Ear, Nose & Throat Surgery

Date:_____

PATIENT FINANCIAL AGREEMENT FORM

Patient Name:_____ Date Of Birth:_____

Dr. Mcalpin requires this form to be signed by her patients. We appreciate your cooperation. If you have any questions, please speak with Billing Department. We are pleased to assist you with your insurance.

1. **Financial Responsibility:** I Understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Dr. Christina M Mcalpin.

I also understand that I will be responsible for any charges incurred by not providing the most current and correct insurance information to Dr. Christina M Mcalpin. Exception to this policy is: those patients with current authorizations with HMO, state or federally funded programs or PPO in which Dr. Christina M Mcalpin is currently contracted with.

Patient or Legal Guardian Signature:_____ Date:_____

2. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**: I hereby authorize payment for medical services provided directly to Dr. Christina M Mcalpin.

Patient or Legal Guardian Signature:_____ Date:_____

Dr. Christina M Mcalpin will be responsible for billing and collection on professional charges. Dr. Mcalpin is not responsible for any bills you may receive from the Hospital including Anesthesia, Pathology or Laboratory services when surgery is performed. Please be aware that most surgery cases performed may require an assistant to be present, not all assistants may be contracted with your insurance policy. We will do our best to acquire a contracted assistant but this is solely based on availability of the assistant. I understand and agree with the terms and conditions listed above.

Patient or Legal Guardian Signature:_____ Date:_____

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Pharmacy Location

Patient Name: _____

Date of birth: _____

Pharmacy Name:
(Please check one)

☐ Rite Aid ~ ☐ Walgreens ~ ☐ Costco ~ ☐ Target ~

☐ CVS ~ ☐ Other pharmacy

Pharmacy address: _____

_____

Pharmacy Number: ( )

Christina M. Mcalpin M.D. Corporacion Profesional

Patient History Form

Patient name: _____ Date of birth: _____

What brings you here today?: _____

Have you ever **had** or do you **have** any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina/Heart attack
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth defect
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ Emphysema
- ☐ Cancer
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Liver problems
- ☐ Lung problem
- ☐ Depression/Anxiety
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Other problem

Have you had **any** type of surgery? ☐No ☐Yes Which one? _____

Do you take medication? ☐No ☐Yes Which ones? _____

_____

Have you ever been admitted to the hospital? ☐ No ☐ Yes When & why? _____

_____

Are you allergic to any medication? ☐ No ☐ Yes Which ones? _____

_____

Family History: What is the health status of your family?

	Medical Problem	If deceased, cause of death
Father:	_____	_____
Mother:	_____	_____
Brother:	_____	_____
Sister:	_____	_____
Others:	_____	_____

Social History:

How much alcohol do your drink daily? _____ Monthly? _____

What kind of alcohol do you drink? _____

How many packs of cigarettes do you smoke a day? _____ For how many years? _____

Do you use **any** illegal drug? ☐No ☐Yes Which one? _____