SPOKANE VALLEY
Ear, Nose & Throat
and Facial Plastics

Otolaryngology-Head & Neck Surgery ■ Board Certified
Facial Plastic & Reconstructive Surgery

WELCOME TO SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS

Spokane Valley Ear, Nose & Throat and Facial Plastics is a group of five physicians specializing in Otolaryngology, Facial Plastics and Reconstructive Surgery. All of our physicians are surgeons and are board certified. Our allergy clinic offers allergy testing and treatment administered by professional and caring RN's. Certified and licensed audiologists offer a wide variety of services, including hearing-aid sales and services with the latest and most successful digital technology. We offer competitive rates with unbeatable service and follow up care. We also offer cosmetic services such as Botox and dermal fillers administered by a board-certified physician.

Our regular office hours are 8:00 AM to 5:00 PM Monday through Friday. We are closed for lunch from 12:00 PM to 1:00 PM. A receptionist will be available at our front desk from 8:00 AM to 5:00 PM. **Emergency calls are available 24 hours every day.** If you need a prescription refilled, for faster service, request it through our patient portal or have your pharmacist send a request to our office.

Since you will be a new patient to our practice, we will require some information about you and your medical insurance coverage. We have enclosed our Patient Registration forms and Personal Medical History form. Please complete ALL paperwork, sign, and return to our office at the time of your appointment or sooner. This will enable us to begin to set up your account.

When you arrive at our office for your first appointment, we will need a copy of your medication list (if you have one) as well as copies of your insurance card(s) and a picture ID. **PLEASE BE SURE TO BRING THESE WITH YOU. We cannot begin to bill your insurance without a copy of your card(s).** If you are not able to provide us with a current copy of your card(s) at the time of your appointment, we will need to reschedule your appointment. If your insurance requires a referral please be sure it is in place prior to your appointment.

If you are bringing in a minor and are NOT the parent/legal guardian we will need written permission from the parent/guardian allowing you to accompany the minor. Important: All paperwork for the patient MUST be completed and signed by a parent/legal guardian. If you are a foster parent or a court appointed legal guardian of a minor, we will need supporting documents for the patient's chart.

Your appointment time as a new patient will usually require approximately 45 minutes. We have set aside this time in the doctor's schedule for you. If, for some reason, you are not able to keep the appointment time, please notify our office at least 24 hours in advance so that we may accommodate other patients.

We are HIPAA compliant and all your personal information will be kept confidential.

We intend to deliver the best level of care and service possible to all of our patients. If you have any concerns about our service, I would be happy to discuss those with you.

Thank you and welcome to our office.

Karen Caudill
Office Manager

Eric B. Leavitt, M.D. ■ Charles F. Benage, M.D. ■ Geoffrey G. Julian, M.D. ■ Omar F. Husein, M.D. ■ Nicholas C Van Buren, M.D.
Wendy Traynham, Au.D., CCC-A, ■ Katie Grote, M.A., CCC-A ■ Clixie Larson, M.A., CCC-A ■ Raymon McNiven, M.A., CCC-A

1424 N. McDonald ■ Suite 101 ■ Spokane Valley, WA 99216
PH: (509) 928-7272 ■ Fax: (509) 928-7346

MINOR PATIENT INFORMATION

How did you hear about our practice? _____

Patient Name: _____
First M.I. Last

Date of Birth: _____/_____/_____ Age: _____ Sex: [] M [] F Race: _____ Ethnicity: _____

Mailing Address: _____

City _____ State_____ Zip: _____

Primary Phone (____) _____ Secondary Phone: (____) _____

Minor living with: ☐ Both Parents ☐ Mother ☐ Father **Legal Guardian:** ☐ Parents ☐ Other (Please see below)

Father: Name: _____ Date of Birth: _____/_____/_____SSN _____

Phone: (____) _____ Email: _____ Employer: _____

Mother: Name: _____ Date of Birth: _____/_____/_____ SSN _____

Phone: (____) _____ Email: _____ Employer: _____

Legal Guardian if not Parent: Name: _____Date of Birth: _____/_____/_____

SSN _____ Phone: (____) _____ Email: _____

Employer: _____

Primary Insurance _____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Mom ☐ Dad ☐ Other: _____
Name / DOB/ Employer

Secondary Insurance _____
Company Name ID Number Group Number

Policyholder for insurance: ☐ Mom ☐ Dad ☐ Other: _____
Name / DOB/ Employer

Preferred Pharmacy: _____
Name Location

Referring Physician: _____ Primary Care Physician: _____

IMPORTANT:

Will anyone other than the parent/legal guardian bring the patient to an appointment? ☐ Yes ☐ No
If yes, please complete Advanced Consent form.

_____ _____
Signature of Parent or Legal Guardian **Date**

2017

***** PLEASE TURN OVER, READ & SIGN*****

2017