

Patient Registration

- Female
 Male

Date _____

PATIENT'S LAST NAME			FIRST			MIDDLE		
AGE	DATE OF BIRTH	STREET ADDRESS				APT. NO.		
CITY		STATE		ZIP	SOCIAL SECURITY NO.			
HOME PHONE	BUSINESS PHONE	CELL PHONE/PAGER	EMAIL ADDRESS		MARITAL STATUS			
OCCUPATION		EMPLOYER'S NAME		ADDRESS				
EMERGENCY CONTACT (Name and address)					TELEPHONE			

REFERRAL INFORMATION

REFERRED BY:	LAST NAME	FIRST NAME
PHONE NUMBER	ADDRESS	

FINANCIAL RESPONSIBILITY (IF SAME AS ABOVE, CHECK HERE - OTHERWISE PLEASE COMPLETE THIS SECTION)

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NO.	RELATION TO PATIENT
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	EMPLOYER NAME AND ADDRESS		

CREDIT CARD INFORMATION – VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER-PLEASE CIRCLE YOUR CARD NAME

NAME ON CARD	CARD NO.	EXPIRATION	SIGNATURE
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INSURANCE – PRIMARY POLICY HOLDER INFORMATION

NAME OF INSURANCE COMPANY	<input type="checkbox"/> HMO	POLICY HOLDER'S NAME-RELATION	HOLDER'S BIRTHDAY
	<input type="checkbox"/> PPO		
	<input type="checkbox"/> POS		

I consent to treatment necessary for the care of the above named patient.
 I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
 I allow fax transmittal of my medical records if necessary.
I acknowledge full financial responsibility for services rendered by Los Angeles Ear, Nose and Throat Associates, and authorize transfer of all unpaid amounts to my credit card after 120 days from the date of service.
 I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Los Angeles Ear, Nose and Throat Associates.
 I have read fully and acknowledge understanding the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Signature _____

Date _____