

Today's Date _____

Patient Information

Name _____ Date of Birth _____ Age _____
last name first name m.i.

Address _____
street apt # city state zip

Mailing Address _____
If different than above city state zip

Home Phone () _____ Sex: M F Status: S M D W

Additional Information for PATIENT or Guardian (Required)

Name of responsible person if other than patient or if patient is a minor _____

Relationship to Patient _____ Date of Birth _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ E-Mail _____

Social Security # _____ Driver's License #/State _____

Place of Birth _____ Occupation _____

Emergency Contact Information

Name of Person to Contact _____

Phone () _____ Relationship to Patient _____

Name of Nearest Relative Not Living With You _____

Phone () _____ Relationship to Patient _____

Insurance Information

Primary Insurance

Secondary Insurance (Courtesy only)

Insurance Co. Name _____

Subscriber Name _____

Subscriber I.D. # _____

Group or Policy # _____

Subscriber Date of Birth _____

Relationship to Patient _____

Insurance Co. Name _____

Subscriber Name _____

Subscriber I.D. # _____

Group or Policy # _____

Subscriber Date of Birth _____

Relationship to Patient _____

Updated Information (Use for return visits only)

I have reviewed all information shown above and there are **NO** changes at this time.

Signature _____ Date _____ Signature _____ Date _____

How Did You Hear About Us?

Reason for Consultation _____

Referred By _____ Specialty _____

Address _____ Phone () _____

Or Yellow Pages Relative Friend Employee Event Other _____

Who is your Primary Care Physician? _____

Address _____ Phone () _____

Consent to Treatment

I hereby request and consent to treatment for myself or my child at California Ear Institute, California Sinus Institute or Let Them Hear Foundation.

Signature of patient or guardian

Date

Medical Records Release

I authorize the release of any medical records or other information necessary for the processing of medical claims on behalf of myself or my child.

Signature of patient or guardian

Date

Insurance Appeals

I hereby consent for the California Ear Institute or California Sinus Institute to act on my behalf in pursuing any insurance appeals necessary to obtain payment for services rendered. I acknowledge that insurance appeal advocacy does not constitute legal representation, and that I may retain outside legal counsel to participate concurrently, if I so choose.

Signature of patient or guardian

Date

Financial Information

- Please be prepared to pay your co-payment at every visit. Your co-payment amount is usually indicated on your insurance I.D. card.
- Please be prepared to pay your deductible (if not met) and any co-insurance amount at the time of your visit.
- Please bring your current insurance I.D. card to every appointment. If you arrive for your appointment and we are unable to verify your insurance coverage or authorization, you may reschedule your appointment to a later date, or you may elect to keep your appointment that day, but will be required to pay for the visit. If you keep your appointment, we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires authorization from your primary care physician, please make sure that you have one that is valid for your visit and that it covers any necessary tests needed.
- We will be happy to bill your secondary insurance as a courtesy. If your insurance fails to pay within 30 days of the primary insurance payment, the balance will be forwarded to you.
- You may be responsible for services defined by your insurance as denied or non-covered.

I have read and understand the financial information above.

Signature of patient or guardian

Date

Other

I would like to receive the Institute's newsletters and/or information about events via e-mail Yes No
(If yes, please include your e-mail address on the front side)

Signature of patient or guardian

Date