Patient Registration Form

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SAN FRANCISCO OTOLARYNGOLOGY
Providing ear, nose, and throat care since 1940

Today's Date _____ **Medical Record** # (for office use) _____

DEMOGRAPHICS

Patient Name _____
Last Name First Name M.I.

Preferred name (nickname)_____ Date of Birth _____ Age: _____

Social Security #_____ Gender: ☐ Male ☐ Female

Mailing Address _____
street apt # city state zip

Primary Phone (_____)_____ Secondary Phone (_____)_____
☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell

Email: _____

ADDITIONAL GOVERNMENT-REQUESTED INFO

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown ☐ Decline to state

Race ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black/African American ☐ White
☐ American Indian/Alaska Native ☐ Other ☐ Unknown ☐ Decline to state

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Preferred Language ☐ English ☐ Spanish ☐ Cantonese ☐ Russian ☐ Other

Needs Interpreter ☐ Yes ☐ No **Appt Reminder Pref:** ☐ Phone ☐ Text

PRIMARY CARE PROVIDER & EMERGENCY CONTACT INFO

Primary Care Provider_____

Referring Provider ***(Who referred you to our practice?)*** _____

Emergency Contacts:

	Primary	**Secondary**
Name	:	
Phone	: ( )	( )
Relationship to Patient	:	
Mailing Address **(optional)**	:	

Please fill next page as well →

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INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No **If you checked no, then fill #1 below, skip #2 and sign at the bottom**

#1. Guarantor Information (person held responsible for the bill):

If the patient is responsible for the bill, skip this section, fill # 2 below for Subscriber information and sign at the bottom

Guarantor Name_____ Date of Birth: _____
(if different from patient) Last Name First Name M.I.

Social Security #_____ Gender: ☐ Male ☐ Female

Phone (_____)_____ Relationship to Patient: _____

Mailing Address _____
street apt # city state zip

Employment Status _____

Employer _____

#2. Subscriber Information:

If the patient is the subscriber, please skip the next few lines, fill employment/coverage information and sign at the bottom

Subscriber Name_____ Date of Birth: _____
Last Name First Name M.I.

Social Security #_____ Gender: ☐ Male ☐ Female

Phone (_____)_____ Relationship to Patient: _____

Mailing Address _____
street apt # city state zip

Employment Status: _____

Employer _____

Coverage Info:

This section can be skipped if you presented the insurance policy card to our receptionist

Coverage Name (Insurance Name):_____

Insurance Policy ID for the patient :_____

Insurance effective Date:_____ Subscriber ID:_____

Signature of patient or parent/guardian:	X	Dated:

Consent & HIPAA

(2 Signatures required)

SAN FRANCISCO OTOLARYNGOLOGY

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Consent to Treatment, Medical Records Release and Insurance Appeals

I hereby request and **consent to treatment** for myself or my child at San Francisco Otolaryngology Medical Group.

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.

I hereby consent for San Francisco Otolaryngology Medical Group 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.

X _____ _____

Signature of patient or parent/guardian Date

Financial Information

- Please be prepared to pay your co-payment and any outstanding balance at the time of your visit. You may be responsible for services defined by your insurance as denied or non-covered
- Please bring your current insurance I.D. card to every appointment. If 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. If you keep your appointment, you will be required to pay for the visit; we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires a referral 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.

Notice of Privacy Practices Acknowledgement

This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. It is available in print form at our front desk or electronic download on our website sfotomed.com.

By signing below, you acknowledge that:

- You have been provided with and understand that San Francisco Otolaryngology Notice of Privacy Practices provides a complete description of the uses and disclosures of your health information
- As part of your health care, San Francisco Otolaryngology Medical Group originates and maintains health records describing your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.
- San Francisco Otolaryngology reserves the right to change its Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address you have provided, if requested.
- You have the right to review San Francisco Otolaryngology Medical Group Notice of Privacy Practices prior to signing this acknowledgement

I have read and understood ALL the information on this page

X _____ _____

Signature of patient or parent/guardian Date