

# Patient Registration Form

Today's Date \_\_\_\_\_

Medical Record # \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last Name First Name M.I.

Responsible Party \_\_\_\_\_ 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 (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Sex: M F Status: S M DP D W Social Security # \_\_\_\_\_ - \_\_\_\_\_

E-Mail \_\_\_\_\_ Driver's License #/State \_\_\_\_\_

I would like to receive educational/informational e-mails

Occupation \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Ethnicity:  Decline to state  Hispanic/Latino  Non-Hispanic/Non-Latino  Unknown  
Race:  American Indian/Alaska native  Asian  Black/African American  Hispanic  Native Hawaiian/Pacific Islander  Other  Decline to state

Primary Language \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

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 \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_

Group or Policy # \_\_\_\_\_

Group or Policy # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## 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 San Francisco Otolaryngology Medical Group.

\_\_\_\_\_

Initial 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.

\_\_\_\_\_

Initial of patient or guardian

\_\_\_\_\_

Date

**Insurance Appeals**

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.

\_\_\_\_\_

Initial 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.

**Notice of Privacy Practice**

San Francisco Otolaryngology Medical Group is committed to protecting the privacy of your medical and personal information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. San Francisco Otolaryngology Medical Group protects your personal and health information in electronic, written and oral forms when used throughout our organization. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of the changes.

So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

I have read and understand the above information.

\_\_\_\_\_

Signature of patient or guardian

\_\_\_\_\_

Date