

DATE: _____

OFFICE USE ONLY: DR: _____ <input type="checkbox"/> NEW <input type="checkbox"/> DELETE <input type="checkbox"/> UPDATE
IF DELETED PATIENT: Last seen: _____ by Dr: _____

PLEASE PRINT NEATLY

Patient Name: _____ Birth Date _____ Age: _____ Sex: _____
(nombre) (Last) (First) (MI) (fecha de nacimiento) (edad) (sexo)

Mailing & Street Address: _____
(domicilio)

City: _____ State: _____ Zip _____
(ciudad) (estado) (codigo postal)

Local Phone#: _____ Work Phone: _____ Cell Phone: _____
(telefono de casa) (telefono de trabajo) (telefono de celular)

Social Security#: _____ - _____ - _____ **(we need your SS# for any testing requested by physician)**
(seguro social) (es necesario para procesar sus exámenes de laboratorio o biopsias)

Status: Married Single Divorced Widow Domestic Partner
(casado(a)) (soltero(a)) (divorciado(a)) (viudo(a)) (pareja domestico(a))

Emergency Contact: _____ Relationship: _____ Phone: _____
(Contacto de emergencia) (relacion) (telefono)

Employer: _____
(Nombre de Empleador)

Address: _____ City: _____ State: _____ Zip: _____
(Direccion) (ciudad) (estado) (codigo postal)

Insurance: _____ Policy Holders Name: _____
Aseguranza (nombre del asegurado)

SSN: _____ DOB: _____ Relationship to Patient: _____
(Seguro social) (fecha de nacimiento) (relacion al paciente)

Referring Physician: _____ Primary Care Physician: _____
(doctor que lo(a) refirio) (doctor particular)

****Continued on reverse side****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Desert Ear, Nose & Throat to release any and all medical records to my insurance company in order to process this or any future medical claims with this office.

Signature: _____ Date: _____

FINANCIAL POLICY

I understand that I am financially responsible for payment due at the time services are rendered by authorize Desert Ear, Nose & Throat. This includes payment in full or, if authorize Desert Ear, Nose & Throat is a contracted provider with my insurance company, any deductible amounts or co-payment amounts which apply at the time of services.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been advised of authorize Desert Ear, Nose & Throat, Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information (if any please state):

PLEASE INITIAL: I give permission I decline my permission for authorize Desert Ear, Nose & Throat to call my home or leave a message on a machine, or to speak to anyone other than myself (*please state name*): _____ to confirm appointments and/or to convey pertinent health information

Signature: _____ Date: _____

Relationship: _____ Witnessed by: _____

OFFICE POLICY FOR TEST RESULTS

If your physician has ordered tests, it is your responsibility to call our office for results. Do not assume that tests are negative just because your physician has not called you. Please allow three business days for turn around time for your results.

Signature: _____ Date: _____