

BAY AREA ENT MEDICAL GROUP

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PATIENT REGISTRATION INFORMATION

Please **PRINT** and complete ALL sections below!

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Widowed
Sex: M F

Name _____

Last Name

First Name

Initial

Street Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Social Security #: _____ - _____ - _____

Date of Birth _____ - _____ - _____ Drivers License (State and #) _____ Age _____

Employer/Name of School _____ [] Full Time [] Part Time

Spouse's Name _____ Work Phone (_____) _____

Last Name

First Name

Initial

How do you wish to be addressed? _____ Spouse's Social Security # _____ - _____ - _____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Date of Birth _____ - _____ - _____

Relationship to Patient Self Spouse Other _____ Social Security # _____ - _____ - _____

Responsible Party's Home Phone (_____) _____ Work Phone (_____) _____

Address _____ Apt _____ City _____ State _____ Zip _____

Employer's Name _____ Phone (_____) _____

Address _____ Apt _____ City _____ State _____ Zip _____

Your Occupation _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist

Copies will be attached below

PATIENT'S REFERRAL INFORMATION

(Please Circle One)

Referred by _____ If referred by a friend may we thank her or him? YES NO

Name(s) of Other Physicians Who Care for You _____

EMERGENCY CONTACT

Telephone: (_____) _____

Name of Person Not Living With You _____ Relationship _____

Address _____ Apt _____ City _____ State _____ Zip _____

ASSIGNMENTS OF BENEFITS • FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to _____ and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Method of Payment Cash Check Credit Card Your Signature _____