WELCOME TO THE SANTA CRUZ EAR, NOSE & THROAT MEDICAL GROUP

BEFORE YOUR VISIT WE NEED THE FOLLOWING INFORMATION
IN ORDER TO ESTABLISH YOUR MEDICAL RECORDS AND SET UP YOUR ACCOUNT.

Mr, Mrs, Ms, Miss (*please circle one*) Date _____

Marital Status (*please circle one*): Married Single Child Other (*Updated info on):* _____*staff:*_____

_____*staff:*_____

Patient's Name _____
Last *First* *Middle*

P. O. Box _____ City/State/ZIP:_____

Address: _____ City/State/ZIP:_____

Home phone# _____ Work phone # _____ Cell # _____

Date of birth: _____ Age _____ □ Male □ Female E-mail address: _____

Contact: _____ Relationship _____ Phone # _____

Social Security #: _____ Driver's license # _____

Primary Physician _____ Referred by:_____

Other Doctors you are seeing _____

PATIENT (or PARENTS) EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____ City/State/ZIP _____

(Parent's) Work Phone # _____

- ***IF PATIENT IS A MINOR:***

MOTHER: _____ FATHER: _____

Social Security #: _____ Social Security #: _____

Address:_____ Address:_____

City/State/ZIP_____ City/State/ZIP _____

Dependent Child's Insurance Carrier:_____

The subscriber is: Mother _____ Father _____

INSURANCE INFORMATION □ ***Copy of card taken***

MEDICAL INFORMATION Smoker _____ Non Smoker _____

Current Medications (including aspirin or other non prescription medicines):

_____

_____

Allergies to Medications? YES _____ NO _____ If so, what? _____

Other Allergies? _____

Prior Surgeries: _____

List any health problems or diagnoses you are being treated for:

_____

_____

SPOUSAL INFORMATION

Spouse's name _____ Date of birth _____

Social Security # _____ Phone # _____

Mailing address _____ City/State/ZIP _____

AUTHORIZATION OF TREATMENT:

I understand that if the doctors at Santa Cruz Ear, Nose & Throat Medical Group consider additional services medically necessary, additional charges may occur and will be billed to my insurance or to my account. (Initial here) _____

Patient: _____

MY SIGNATURE BELOW AUTHORIZES THE DOCTORS AT SANTA CRUZ EAR, NOSE & THROAT MEDICAL GROUP TO TREAT THE ABOVE NAMED PATIENT, INCLUDING OFFICE DIAGNOSTIC PROCEDURES AND TESTS.

Signature of Patient//Parent/Guardian _____ Date _____

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have reviewed a copy of this medical practice's **Notice of Privacy Practices**.

Signature _____ Date _____

Print name: _____

If not signed by the patient, please indicate relationship:

- □ Parent or Guardian of minor patient
- □ Guardian or Conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

Name of Patient: _____

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

For office use only:

- □ *Signed form received by:* _____
- □ *Acknowledgement refused*

Efforts to obtain: _____

_____

Reason for refusal: _____

MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY CLAIM AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Marc A.Seftel, Daniel A.Spilman and/or James A.Teng, for any services furnished me by that pprovider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the insurer or agency shown.
I authorize Santa Cruz Ear, Nose and Throat Medical Group to appeal Medicare claims on my behalf.

Signature _____ Date _____ IB-02/18