

Patient Registration Information

All information must be entered, options circled and all blanks filled in prior to appointment.

PATIENT INFORMATION				
First Name	Middle Initial	Last Name	Date Of Birth	Age
Street Address		City	State	Zip code
Patient Sex	Marital Status	SSN	Preferred Language	
Home Phone Number	Work Phone Number	Cell Phone Number	Ethnicity (circle) Hispanic Non-Hispanic Unknown	
Race (circle): African American Asian White/ Caucasian Native American Other				
PATIENT CURRENT EMPLOYER /SCHOOL (circle) Student Minor Retired Disabled Homemaker Employed Not Employed Full time Part time				
Employer/School/ Daycare Name and Job title:				Phone
Street Address		City	State	Zip code
GUARANTOR INFORMATION				
First Name	Last Name		Date Of Birth	Sex
Street Address		City	State	Zip code
SSN	Employer Name and Job Title:		Work Phone Number	
Home Phone #	Email address		Cell phone #	
CONTACT INFORMATION: If Patient is a Minor list both Parents . Please list two separate people with 2 different phone numbers				
Emergency Contact Name			Home Phone:	
Relationship to Patient		If parent, please list SSN:	Cell Phone:	
Employer Name and Job Title:			Work Phone:	
* _____ Initial to authorize Lawrence Otolaryngology Associates to disclose health information to person listed above				
Secondary Contact or Next of Kin Name:			Home Phone:	
Relationship to Patient		If parent, please list SSN:	Cell Phone:	
Employer Name and Job Title:			Work Phone:	
* _____ Initial to authorize Lawrence Otolaryngology Associates to disclose health information to person listed above				
INSURANCE INFORMATION				
Primary Insurance Name		ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address:		Relation To Patient	Subscriber DOB	Subscriber Sex
I HAVE SECONDARY INS - YES / NO		I HAVE TERTIARY INS - YES / NO		
Secondary Insurance Name		ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address		Relation To Patient	Subscriber DOB	Subscriber Sex
Medicare Patients: Is Patient in a skilled nursing facility? YES / NO If YES, list facility name:				
PRIMARY CARE PHYSICIAN INFORMATION		The following Physicians should have a copy of my office visit note and testing:		
PCP Name:		Referring Physician:		
PCP Phone Number:				

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lawrence Otolaryngology Associates, LLC, 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. I acknowledge financial responsibility for balance due and, in the event of default, agree to pay all collection costs. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree a photocopy of this agreement shall be valid as the original. I understand that no guarantees have been made to me regarding the outcome of this care.

I acknowledge I have been offered LOA notice of privacy practices. I understand that Lawrence Otolaryngology Associates, LLC has made every effort to ensure the privacy of our internet system but cannot guarantee that internet communications are completely confidential. I acknowledge LOA will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this communication waiver at any time. Any revocation or change will not apply to past communications. I understand courtesy appointment reminder calls and other important calls that may be placed using a pre-recorded message and consent to receiving such calls.

I confirm that I have read the above information and it is current and true.

Signature: _____ Date: _____