# 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 infury? 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 INSURACE 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 _____