Lawrence Otolaryngology Associates, LLC Chart #_____

Patient Registration Information

All information must be filled in prior to appointment.

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Preferred Name (if different)	Date of Birth

Street Address/apt#	City	State	Zip code

Cell Phone Number	Home Phone Number	Work Phone Number	SSN

Sex M F	Marital Status	Preferred Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown

Race (circle): African American Asian White/ Caucasian Native American Other

Optional: Additional Gender Identity Info:

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:

GUARANTOR INFORMATION ☐ **Check box if the responsible party is the same as above.**

First Name	Last Name	Date Of Birth	Sex

Street Address	City	State	Zip code

SSN	Employer Name and Job Title:	Work Phone Number
Cell Phone #	Email address	Home phone #

EMERGENCY CONTACT INFORMATION: If Patient is a Minor list both parents. ***Please list two separate people with 2 different phone numbers.***

Emergency Contact Name Cell Phone:

Relationship to Patient If parent to minor, please list SSN: Home Phone:

Employer Name: Work Phone:

** I authorize Lawrence Otolaryngology Associates to disclose health information to the person listed above. ☐ Yes ☐ No

Secondary Contact or Next of Kin Name: Cell Phone:

Relationship to Patient If parent to minor, please list SSN: Home Phone:

Employer Name: Work Phone:

** I authorize Lawrence Otolaryngology Associates to disclose health information to the person listed above. ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Name	ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address, if different than Patient:	Relation To Patient	Subscriber DOB	Subscriber Sex

I HAVE SECONDARY INSURANCE: YES / NO I HAVE TERTIARY INSURANCE: YES / NO

Secondary Insurance Name	ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address, if different than Patient:	Relation To Patient	Subscriber DOB	Subscriber Sex

Medicare Patients: Is Patient in a skilled nursing facility? YES / NO If YES, list facility name:

REFERRING PHYSICIAN INFORMATION

Referring Provider Name:

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. I understand that I may revoke my consent to disclose health information at any time in writing. Any revocation or change will not apply to past communications. I understand this authorization will remain in effect for one year from the date signed unless I specify a date here: _____. I understand courtesy appointment reminder calls, text messages or emails and other important communication may be placed using a pre-recorded message and consent to receiving such communication.

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

Signature: _____ Date: _____