



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 \_\_\_\_\_

**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. Thomas V. Barker, Marc A. Seftel, and/or Daniel A. Spilman for any services furnished me by that provider. 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-04/11