LOS ANGELES SINUS INSTITUTE

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PLEASE PRINT

Patient Name: ____ Male ____ Female ____

If Patient is a Minor, Name of Parent/Responsible Party: ____

Address: _____________________________________ **Apt#:** ______ **Marital Status:** ______

City: ____ **State**: ______ **Zip Code:** __________

Date of Birth ______ /______ /______ **Age**: _____

Driver's License # _______________________

Home Telephone # (_____)________________

Cell Phone # (_____)______________________

Email Address: _________________________

Emergency Contact: _____________________

Relationship: ___________________________

Telephone #: (_____)______________________

Social Security #________________________

Occupation: ___________________________

Employer Name: ________________________

Work Telephone #: (_____)________________

Insurance Company:_____________________

ID.No/SSN: ___________________________

Insured Name: _________________________

Insured Date of Birth: _____ / ______/ ______

Whom shall we thank for referring you? ____

Personal Physician: __________________________ **Telephone #:** (_____)_____________________

Address: ___________________________**City:** ________________ **State:** ____ **Zip Code:** ______

AUTHORIZATION:

May we send your physician a report of our findings? Yes ________ No ________

I authorize the release of medical information to my insurance company: Yes ________ No ________

BILLING POLICY:

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medi-cal or legal liens.

I have read the above policy and understand my financial responsibility.

Signature: ____ **Date:** _____ / ______/ ______