

**Lawrence Otolaryngology Associates, P.A.**

Patient Registration Information

**(All missing or incomplete information must be completed prior to appointment)**

<b>PATIENT INFORMATION</b>			
First Name and Middle Initial	Last Name	Date Of Birth	Age
Street Address	City	State	Zip code
Patient Sex:	Marital Status:	SSN:	Date This Form Was Printed
Home Phone Number:	Work Phone Number	Cell Phone Number	E-mail Address:

<b>PATIENT CURRENT EMPLOYER /SCHOOL</b>	<b>Student? Yes / No</b>	<b>Full Time / Part Time</b>	<b>Please Enter School Info Below</b>
Employer (Company Name/ School Name):			Phone
Job Title:			
Street Address	City	State	Zip code

<b>GUARANTOR INFO. Home Phone #:</b>		<b>Cell Phone #</b>	<b>E-Mail Address:</b>
First Name	Last Name	Date Of Birth	Sex
Street Address	City	State	Zip code
SSN	Employer (Company Name) Job Title and Work Phone Number:		

<b>CONTACT INFORMATION</b>		<b>If Patient is a Minor list both Parents</b>	<b>Please list two separate people.</b>				
<b>Emergency Contact Name</b>	Relationship	Address	City	ST	Zip	Home Phone	Cell Phone
Emergency Contact Employer and Job Title:						Work Phone:	
<b>Next of Kin Name</b>	Relationship	Address	City	ST	Zip	Home Phone	Cell Phone
Next of Kin Employer and Job Title:						Work Phone:	

<b>PRIMARY INSURANCE INFORMATION</b>			
<b>Insurance Requires a Referral</b> Yes / No Initial _____	<b>I have a MEDICARE "REPLACEMENT" PLAN - Yes / No Initial _____</b>		
<b>GIVE INSURANCE CARDS TO RECEPTIONIST</b>		<b>COPAY IS DUE AT TIME OF SERVICE</b>	
Insurance Name And Customer Service Phone #		ID/Certificate Number	Group ID/Number
Policy Holder (Subscriber) Name	Relation To Patient	Subscriber Birth Date	Subscriber Sex

<b>SECONDARY INSURANCE INFORMATION</b>			
Insurance NameAnd Customer Service Phone #		ID/Certificate Number	Group ID/Number
Policy Holder (Subscriber) Name	Relation To Patient	Subscriber Birth Date	Subscriber Sex

<b>Primary Care Physician Information</b>	<b>The following Physicians should have a copy of my office visit note and testing.</b>
PCP Name:	
PCP Phone Number:	

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lawrence Otolaryngology Associates, P.A., 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 understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original. I acknowledge that I was provided with the Notice of Privacy Practices from Lawrence Otolaryngology Associates, P.A. This authorization expires upon written notice from the patient. I understand I have a right to revoke this authorization in writing except to the extent Lawrence Otolaryngology Associates, P.A. has taken action or has relied upon the authorization. This authorization may be revoked in writing delivered to Lawrence Otolaryngology Associates, P.A. The information disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected under federal privacy laws. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number and signing below you consent to receiving such calls.

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

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

Notice: Lawrence Otolaryngology Associates, P.A. has made every effort to ensure the privacy of our Internet system; however, we do not guarantee that Internet communications are completely confidential. LoA HIPPA rev. May. 2008