PACIFIC
EAR, NOSE & THROAT
ASSOCIATES, INC.

929 Clay Street, Suite #501
San Francisco, CA 94108
415-433-7945
www.PacificENTSF.com

Patient Registration Form 病人登記表

Patient Name 姓名:	Primary Phone 電話# _____ (Home, Cell, Work)	Other Phone 電話# _____ (Home, Cell, Work)
Patient address 地址:	Emergency Contact 緊急聯繫人 Name 姓名: Address 地址: Phone 電話: Relationship 關係:	
Date of Birth 出生日期: _____/_____/_____ Gender 性別: Male男 Female女 Marital Status 婚姻狀態: _____ Social Security 工卡#: _____-_____-_____ State ID/ Driver's License 身份證: _____	Parent/Guardian (if minor) 家長 / 監護人 or Financial Responsible party 財務負責人: Address: Parent/Guardian SSN: ___-___-_____	

Employment Information 工作質料
Employer 雇主:
Address 工作地址:
Business Phone 工作電話: Occupation 職業:

Drug allergy 藥物過敏: _____ ☐ No Allergy /Unknown 沒有 / 不清楚
Height 體重: _____ Weight身高: _____
Smoking Status 吸煙狀況: ☐ Current 吸煙者 ☐ Former 曾經吸煙 ☐ Never 從來不吸煙

Pharmacy Where You Pick Up Medications 你經常去的藥房
Name 藥房名: _____ Phone Number 藥房電話號碼: (___)_____
Address 藥房地址: _____

Race 種族:
☐ Asian 亞洲人 ☐ African American ☐ American Indian ☐ Caucasian ☐ Hispanic
☐ Pacific Islander ☐ Other _____ ☐ Decline to Provide

Ethnicity 族裔:
☐ Hispanic 西班牙裔 ☐ Non-Hispanic 非西班牙裔 ☐ Unknown ☐ Decline to Provide

Primary Language 語言:
☐ Cantonese 廣東話 ☐ Mandarin 國語 ☐ Vietnamese ☐ English ☐ Other_____

Insurance Information 醫療保險 Plan Name: Subcriber ID#: Subcriber's Name: Subcriber's Date of Birth: Relationship to Patient:	Referring Physician 介紹醫生 Primary Care Physician 家庭醫生

Pacific Ear, Nose & Throat Associates, Inc.

Patient Conditions, Consent, Financial Agreements, Acknowledgement of Privacy Practices

Medical and Surgical Consent: The undersigned consents to medical/surgical treatment which may be performed, including diagnostic procedures, anesthesia, medical or surgical treatment or procedures rendered to the undersigned under the general and special instructions of the patient's physician, assistants, or designees. The undersigned also agrees that Pacific ENT Associates may obtain electronic files from other healthcare providers or third party benefit payors of any results or information necessary to render treatment, such as health information, diagnostic test results or prescription medications.

Release of Information: For purposes of determining liability for payment and obtaining reimbursement, the patient (or the patient's legal representative) agrees that Pacific ENT Associates may disclose the patient's record, including their medical records, to any person, corporation, governmental body or other entity which is or may be liable, or which is involved in ruling on liability or who may assume or has assumed liability for all or any portion of charges including but not limited to: insurance companies, health care service plans, workers' agencies.

Assignment of Health Plan Benefits: The patient (or patient's representative) hereby assigns to Pacific ENT Associates any health insurance or health plan benefits payable to the patient (or to the patient's representative) by an insurer or health plan for the medical/surgical treatment provided to the patient. The patient (or patient's representative) signing below authorizes any health plan or health insurer to pay directly to Pacific ENT Associates for such services. This assignment pertains to benefits payable for health care costs or services of any kind payable from any source. The patient (or patient's representative) agrees not to interfere with Pacific ENT Associates' ability to rightfully obtain payment from any health plan or insurer. Nothing herein shall be construed as altering or modifying in any way the patient's responsibility for payment in full for goods and services received.

Medicare Patients Only: Patient's Certification, Authorization to Release Information, and Payment Request
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or other related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Financial Agreement: I certify that I am eligible for benefits under the insurance plan shown on the reverse side of this form and I hereby authorize payment of medical insurance benefits due to myself or my dependents to Pacific ENT Associates. I recognize that it is my responsibility to check with my insurance carrier or health care service plan prior to obtaining services to discover whether or not services are covered. I understand that I am responsible for co-payments, deductible amounts, non-covered services, and any other fees not paid by my insurance at the time services are provided. I agree that I am fully responsible for payment for services provided by Pacific ENT Associates if I fail to obtain proper authorization, referral or pre-certification necessary under my insurance plan, if I fail to make the requisite inquiry to determine whether or not services are covered, or to verify that the physician I am seeing is a provider for my insurance plan.

Cancellation fees may be assessed if appointments for office visits or elective surgical services are not cancelled in advance. A billing fee of $30 or more may be assessed if copays are not paid at the time of services. Past due balances may be assessed 18% interest 60 days after: the date services were provided (if private pay) or the initial billing date subsequent to the receipt of any insurance payments. Accounts refereed to any attorney or agency for collection may be assessed fees for collection and interest on unpaid balances. I acknowledge my responsibility for these additional fees should they become necessary.

The undersigned certifies that he/she has read for foregoing and is the patient or is duly authorized by the patient (as the patient's parent or general agent) to execute the above and accept its terms.

☐ Chinese Summary Provided, per Request

_____	_____
Patient's Signature	Signature of Responsible Party or Agent (for the patient)
_____	_____
Date Signed	Name of Responsible Party or Agent

The undersigned further certifies that he/she:

Received or had access to a copy of Pacific ENT Associates Notice of Privacy Practices

_____
Patient/Parent/Guardian's Signature Date