Rom R. Karin, M.D. David P. Arnstein, M.D. William S. Lewis, M.D.

Patient Information

Date: _____

Name _____

Birth Date _____ Age _____ ☐ M ☐ F Email Address _____

Social Security # _____ Driver's License # _____

Address _____
Address City State Zip

Race/Ethnicity _____ ☐ Decline

Home Phone # _____ Cell Phone # _____

Person to contact in case of emergency _____
Name Address Phone #

Employer Address Work Phone #

Spouse's Name Birth Date Social Security #

Spouse's Employer Address Employer Phone #

Dependent Patient Information

Mother/Guardian's Name Birth Date Social Security # Drivers License #

Home Address (if different) Phone # (if different)

Mother's Employer Mother's Work Phone #

Father/Guardian's Name Birth Date Social Security # Drivers License #

Father's Employer Father's Work Phone #

Billing Information

_____ The doctor is a non-preferred provider for my insurance. I understand my out-of-pocket expenses will be higher and I am responsible for the payment of services.

_____ I do not have insurance and will pay for my services at the time of my visit.

_____ I have insurance with which the doctor is contracted. The billing staff will submit my claim for payment to my insurance company.

Primary Insurance

Carrier _____

Subscriber's Name _____

Subscriber's Birth Date _____

ID# _____

Group # _____

Effective Date _____

Address for Claims Submission _____

_____

_____

Secondary Insurance

Carrier _____

Subscriber's Name _____

Subscriber's Birth Date _____

ID# _____

Group # _____

Effective Date _____

Address for Claims Submission _____

_____

_____

Who referred you: ☐ Physician _____ ☐ Internet / Web Site ☐ Family / Friend

Primary Care Physician _____

Preferred Local Pharmacy _____

I authorize the processing of my medical insurance claim(s) by the Ear, Nose & Throat of Los Gatos (ENTLG). My signature authorizes the payment to ENTLG of all medical and surgical benefits to which I am entitled. I further authorize ENTLG to contact my insurance carrier(s) and to release all information necessary to secure payment. I recognize my financial obligation to pay any co-payments, co-insurance, deductible and non-covered services. Co-payments and fees for services for non-preferred insurances are due at the time of service. Full payment for services is expected within 90 days of services. An account balance 90 days and older for which patient liability has been determined will accrue finance charges not to exceed 10% per annum.

I give permission to the doctors at Ear, Nose & Throat of Los Gatos to pull my prescription history via Surescripts.

I also acknowledge that I understand the doctors do not accept Medi-Cal.

My signature indicates my acknowledgment and acceptance of the above policies.

_____ _____

Patient/Guarantor's Signature Date