STEPHEN A. LANDERS, M.D.
DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

PEDIATRIC AND ADULT
EAR, NOSE & THROAT

REGISTRATION

PATIENT INFORMATION

Name _____ SSN _____
Last First Initial

List all other names used _____

Sex ☐M ☐F Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Home Phone _____ Cellular Phone _____

Physical Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

In case of an emergency who should we notify (name, relationship, phone & address)? _____

_____

Does your insurance plan include prescription benefit coverage? ☐Yes ☐No

What pharmacy do you use? _____ Phone _____

Known drug allergies _____

Primary Care Physician's Name _____

Whom may we thank for referring you? _____

How did you hear about us? _____

INSURANCE

PLEASE NOTE: All copay, coinsurance, non-covered charges and unmet deductible amounts are due and payable at the time of service.

PRIMARY INSURANCE (Billed 1st)

Insurance Co Name _____
Address _____
City, St, Zip _____
Phone _____
Member's Name _____
Address _____
City, St, Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
City, St, Zip _____
Phone _____

SECONDARY INSURANCE (Billed 2st)

Insurance Co Name _____
Address _____
City, St, Zip _____
Phone _____
Member's Name _____
Address _____
City, St, Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
City, St, Zip _____
Phone _____

SELF PAY: Please notify receptionist of payment method. We accept cash, checks and all major credit cards. Payment is expected at the time of service.

--CONTINUED ON BACK--

(214) 691-0800
FAX: (214) 691-0801
E-Mail: drlanders@drlanders.com
Web Site: www.drlanders.com

7515 Greenville Ave., Suite 806
Dallas, Texas 75231

1004 N. Washington
Dallas, Texas 75204

CONFIDENTIAL COMMUNICATIONS

You have the right to request that you receive communications regarding your protected health information in a manner and/or location of your choosing. Please complete the information below to assist us in meeting your needs. **I wish to be contacted in the following manner (check all that apply):**

☐ Home Telephone _____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave detailed message
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address

☐ Email _____

☐ Fax _____

☐ Other _____

_____

CONSENT

By signing this form I authorize the practitioners at Dr. Landers, to provide medical treatment and other such services as they may deem necessary. I understand that there are no express or implied guarantees regarding the results of any medical treatment provided at this clinic.

By signing this form I acknowledge that I have read and understand the *Notice of Privacy Practices* given to me at the time of initial registration which provides detailed information about my rights and how and under what circumstances my protected health information may be used and disclosed. I understand that my health information may be used and disclosed in accordance with the *Notice of Privacy Practices* so that any treatment and/or services I receive at this clinic may be billed to and payment collected from me, an insurance company, and/or other third party.

I understand that I am financially responsible for payment in full for services rendered whether or not paid by insurance. Furthermore, by signing this form I agree to directly assign to Dr. Landers all insurance benefits, if any, otherwise payable to me for services rendered. I certify that the information I provide on this form is complete and accurate.

_____ _____

Signature **Date**

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