STEPHEN A. LANDERS, M.D.

DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

PEDIATRIC AND ADULT
EAR, NOSE & THROAT

REGISTRATION

(Minor/Dependent)

PATIENT INFORMATION

Name ______________________________ SSN ______________
Last First Initial

Sex ☐ M ☐ F Age __________ Birthdate __________ Home Phone __________

Address ______________________ City __________ State ______ Zip ______

Who has legal custody (Name & Relationship)? ______________________

Who has consent for medical care in an emergency if we are unable to reach you (Name, Relationship, Address & Phone)?

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Primary Care Physician's Name ______________________

Whom may we thank for referring you? ______________________

How did you hear about us? ______________________

PAYMENT POLICY

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

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

PARENT/GUARDIAN

MOTHER'S Name ______________________
Street Address ______________________
Mailing Address ______________________
City, St, Zip ______________________
Home Phone ______________________
SSN __________ Birthdate __________
Employer Name ______________________
Address ______________________
City, St, Zip ______________________
Phone ______________________

FATHER'S Name ______________________
Street Address ______________________
Mailing Address ______________________
City, St, Zip ______________________
Home Phone ______________________
SSN __________ Birthdate __________
Employer Name ______________________
Address ______________________
City, St, Zip ______________________
Phone ______________________

NON-CUSTODIAL PARENT (If applicable)
Name ______________________
Street Address ______________________
Mailing Address ______________________
City, St, Zip ______________________
Home Phone ______________________
SSN __________ Birthdate __________
Employer Name ______________________
Address ______________________
City, St, Zip ______________________
Phone ______________________

INSURANCE

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 2nd)
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 ______________________

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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 ______________________

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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**