

## STEPHEN A. LANDERS, M.D.

DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

## REGISTRATION

(Minor/Dependent)

Name	PATIENT INFORMATION		
Lat       Fast       Itend         Lat       Birthdate	Name	SSN	
Address	Last First Initial		
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)?         Primary Care Physician's Name         Whom may we thank for referring you?         How did you hear about us?         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       INSURANCE         MOTHER'S Name       Insurance Co Name         Mailing Address       City, St, Zip         City, St, Zip       Birthdate         Home Phone       Birthdate         SN       Birthdate         FATHER'S Name       Birthdate         Gity, St, Zip       Phone         Phone       Birthdate         FATHER'S Name       City, St, Zip         SN       Birthdate         Employer Name	-		
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Street Address	MOTHER'S Name	PRIMARY INSURANCE (Billed 1 <sup>st</sup> )	
Mailing Address       Address         City, St, Zip       City, St, Zip         Home Phone       SN         SN       Birthdate         Address       City, St, Zip         City, St, Zip       Member's Name         Address       City, St, Zip         Phone       SSN         FATHER'S Name       Group#         Street Address       ID#         Mailing Address       City, St, Zip         Mailing Address       City, St, Zip         Mailing Address       City, St, Zip         Mome Phone       SSN         Street Address       City, St, Zip         Home Phone       SECONDARY INSURANCE (Billed 2 <sup>nd</sup> )         Insurance Co Name       Address         City, St, Zip       Phone         Phone       Phone         Name       City, St, Zip         Name       City, St, Zip         Street Address       City, St, Zip         Mailing Address       City, St, Zip         Mailing Address       SSN         Street Address       Phone         Street Address       Phone         Street Address       Sinhate         Street Address       Sinhate <td< td=""><td>Street Address</td><td>Insurance Co Name</td></td<>	Street Address	Insurance Co Name	
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	Phone	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	□ Written Communication
$\Box$ O.K. to leave detailed message	$\Box$ O.K. to mail to my home address
Leave message with call-back number only	$\Box$ O.K. to mail to my work address
Work Telephone	Email
$\Box$ O.K. to leave detailed message	□Fax
□ Leave message with call-back number only	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 <u>Notice of Privacy Practices</u> 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 <u>Notice of Privacy Practices</u> 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