MATTHEW L. FINERMAN, M.D., INC.

HEAD & NECK SURGERY ~ ADULT & PEDIATRIC EAR, NOSE & THROAT ~ ENT ALLERGY ~ NASAL/SINUS DISORDERS ~ SNORING

PLEASE PRINT

Patient Name _____
LAST FIRST MIDDLE

Date of Birth _____ /_____ /_____ Social Security Number: # _____-_____ -_____ Male____ Female ____
MONTH DAY YEAR

Primary Language: _____Race: _____ Ethnicity: _____

Address_____City/State/Zip: _____

Primary Contact Number: (_____) _____ Secondary Number: (_____)_____
[ ] Cell [ ] Home [ ] Work [ ] Cell [ ] Home [ ] Work

Email Address: _____
We keep your email strictly confidential and do not share your personal information. Please check here if you do not wish to receive emails [ ]

Emergency Contact: _____Relationship: _____Telephone #: (_____)_____

** If Patient is a Minor, Name of Parent/Responsible Party:*_____

PERSONAL PHYSICIAN - Does the Patient have a Personal Physician? Yes [ ] No [ ]

If *yes*, may we send your physician a report of our findings? Yes [ ] No [ ]

Physician Name _____ Telephone Number: (_____)_____

HOW DID YOU FIND US? (check all that apply)

*Physician [ ] Dr. Name: _____ Phone: _____

*Insurance Provider [ ] *Family/Friend [ ] *Online/Google Search [ ] *Yelp [ ]

*FaceBook [ ] * Other [ ] (if other, please list)_____

AUTHORIZATION: I authorize the release of medical information to my insurance company: Yes ___ No ____

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medi-cal or legal liens.

I have read the above policy and understand my financial responsibility.

✓ **SIGNATURE OF RESPONSIBLE PARTY**: _____ Date _____ /_____ /_____
MONTH DAY YEAR

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