WELCOME TO THE LOS ANGELES CENTER FOR EAR, NOSE, THROAT AND ALLERGY

Please Fill Out the Information Below

Patient Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

Home/Cell Phone:_____ Work Phone: _____

Email:_____ DOB: _____

Social Security #: _____ Driver's License #_____

Emergency Contact (Name/Phone):_____

Primary Care Physician (Name/Phone):

Acknowledgment of Receipt of Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

NOTICE ON WALL

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING IT
- OTHER (PLEASE SPECIFY):_____

As patient or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT &RELEASE: I hereby assign my insurance benefits to be paid directly to The Los Angeles Center for Ear, Nose, Throat & Allergy. I am fanatically responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

I state that this information is correct to my knowledge. I have read and agree to comply with the office policy stated in the patient information sheet.

SIGNED_____ DATE:_____

LOS ANGELES CENTER FOR EAR, NOSE, THROAT AND ALLERGY
1700 E CESAR E CHAVEZ AVE, SUITE 2500
LOS ANGELES, CA 90033
Phone: (323) 268-6731 Web: www.laentdoctors.com