

Nina J. Lee-Tall, M.D, Inc.

Otolaryngology Head and Neck Surgery
Adult and Pediatric Ear Nose and Throat
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PATIENT'S INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ SEX: M/F

BIRTH DATE: / / MARITAL STATUS: _____ DRIVER'S LIC#: _____ SS#: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE (HOME): _____ (CELL): _____ (WORK): _____

Which is the best number to contact you during business hours? _____ OCCUPATION: _____

EMPLOYER: _____ PARENT (IF UNDER AGE 18): _____

EMERGENCY CONTACT: _____ (Name of a friend/relative not living at same address)

PHONE: _____ CELL/WORK: _____ RELATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

DO WE HAVE PERMISSION TO:

- Leave a message on your answering machine? Yes/No (Circle)
- Leave a message on your cell phone? Yes/No (Circle)
- Leave a message at work? Yes/No (Circle)
- Discuss your medical condition with anyone? Yes/No (Circle)
- If yes, please give name(s): _____

BILLING INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S BIRTH DATE: / /

RELATION TO SUBSCRIBER (CIRCLE): SELF / SPOUSE / CHILD / OTHER

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Dr. Nina Lee-Tall, M.D., or my insurance company to release any information required to process my claim.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. If I only have Medicare I will be responsible for whatever Medicare does not cover. This includes (United Healthcare, TriCare as secondary) since we have NO contract with these insurances.

PATIENT/ GUARDIAN SIGNATURE: _____ DATE: _____