MATTHEW L. FINERMAN, MD

OTOSURGICAL GROUP MEDICAL CLINIC, INC.

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PLEASE PRINT

Patient Name _____ Male____ Female ____
LAST FIRST MIDDLE

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

Address: _____ Apt#: _____ **Marital Status** _____

City: _____ State: _____ Zip Code: _____

Date of Birth _____ /_____ /_____ **Age**: _____ **Social Security #** _____
MONTH DAY YEAR

Driver's License # _____ **Occupation**: _____

Home Telephone # (_____) _____ **Employer Name**: _____

Cell Phone # (_____)_____ Work Telephone # (____) _____

Email Address: _____ **Insurance Company**: _____

Emergency Contact: _____ ID.No/SSN: _____

Relationship: _____ **Insured Name**: _____

Telephone # (_____)_____ Insured Date of Birth: _____ / _____/ _____
MONTH DAY YEAR

Whom shall we thank for referring you? _____

Personal Physician _____ Address: _____

City: _____ State: ____ Zip Code:_____ Telephone # (_____)_____

May we send your physician a report of our findings? Yes _____ No _____

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**: _____ **Date:** _____