NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Rd, Ste A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

ADULT PATIENT REGISTRATION Today's Date __________________

Patient Name __________________________________ Date of Birth ___/____/____ Age _____

Phone Numbers: H _________________ W _________________ Cell __________________

Street Address _______________________________ City___________________ Zip__________________

Email Address _____________________________________ Patient Social Security # __________________

Emergency contact name and phone number: ____

Preferred Language _______________________ Interpreter name and phone number___________________

Can we leave voice mail messages with health information at the above number(s) and relay health information

(such as test results) to whomever answers at the above number(s)? Yes____ No____

Referring Provider __________________________ **Primary Care Provider** ___________________________

Insurance information

Member's Name ___________________ Social Security #: ____________ Employer ___________________

Primary insurance __________________________________ Policy # ______________________________

Secondary insurance _______________________________ Policy # _______________________________

Insurance preferred lab ____________________ Insurance preferred radiology facility__________________

Release/Assignment/Acknowledgement

I hereby authorize North County Ear, Nose and Throat, Head and Neck Surgery, Inc. to release pertinent information to other health care providers involved in my dependent's care and/or insurance companies holding policies on my dependent.
I authorize my insurance company to directly remit payment to North County Ear, Nose and Throat, Head and Neck Surgery, Inc. for medical and surgical services provided.
I understand that I am ultimately responsible for all charges incurred. It is my responsibility to know my insurance and make sure that if I am using an HMO my dependent has an authorization from their primary care doctor and/or insurance company to see this doctor.

I understand that by not providing the office with all information requested and/or copies of my insurance card(s) at the time of service, this could delay the processing of my claim and I could be personally responsible for payment of these services.
Notice to consumers: I understand that medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbca.gov
Privacy Notice Record-I acknowledge that I have received a copy of the Notice of Privacy Practices. My signature below indicates my acceptance~~/understanding~~ of the above statements.

Signature of patient or legal guardian____ Date _____________

NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Rd, Ste A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

Today's Date ____________________

ADULT PATIENT MEDICATION FORM

1. Patient Name: ____ **Date of Birth** ___/____/____

2. Pharmacy information: Please list the name, phone number and address of your preferred **pharmacy**:

Pharmacy name: ____ Phone Number: ________________________

Street Address: ______________________________________ City_____________________ ZIP Code ______________

3. Medications: Please list **all** medications you are currently taking (including herbal supplements, vitamins, aspirin, nasal sprays, other “over-the-counter” medications, etc.) and **dosage:**

Check here if none ☐

Medication	**Dosage**	**Medication**	**Dosage**

4. Allergies: Please list any allergies and the type of reaction (include medications, latex, xray dye, food, environmental):

Check here if none ☐