ENT & SINUS CENTER
8241 Rochester Avenue, Suite 130, Rancho Cucamonga, CA 91730
P 909-466-8400 F 909-466-8410

Henry H. Nguyen, M.D.
Diplomate - American Board of Otolaryngology

Deborshi Roy, M.D.
Diplomate - American Board of Otolaryngology
American Board of Facial Plastic & Reconstructive Surgery

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Emergency Phone: _____ Sex: _____ Marital Status: ____

Birth Date: _____ Social Security # _____

Patient's Employer: _____ Employer Phone: _____

Employer Address: _____

Referring physician: _____ Family Physician: _____

INSURANCE INFORMATION:
PRIMARY INSURANCE: _____

Group #: _____ Policy #: _____ Copay: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Sex: _____ DOB: _____ SSN: _____

Subscriber Employer: _____ Work Phone: _____

Employer Address: _____

SECONDARY INSURANCE: _____

Group #: _____ Policy #: _____ Copay: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Sex: _____ DOB: _____ SSN: _____

Subscriber Employer: _____ Work Phone: _____

Employer Address: _____

IF COVERED BY A THIRD INSURANCE, PLEASE CHECK HERE _____

X_____/_____ _____
Patient signature Parent signature (if minor) Printed name

Name of person responsible for any co-insurance or payments: _____

Relationship to Patient: _____

Address if different from above: _____

Phone: _____

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AUTHORIZATION FOR TREATMENT AND MEDICAL INFORMATION RELEASE

The purpose of medical care is to treat disease, injury and disability by examination, testing and use of procedures in the aid of diagnosis or treatment, and also to obtain information needed in diagnosing and examining patients.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he or she remains personally responsible for payment. However, as a courtesy to our patients, we will submit a claim to your insurance company and in doing so, the responsible party authorizes his/her insurance company to pay directly to the doctor and medical service provider.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All bills are due and payable at the time services are rendered. Any other arrangements must be made in advance. We reserve the right to add a late charge on overdue balances and to add Collection fees to the balance should the account have to be placed with a Collection agency or other such service.

I also understand that there will be a 2% surcharge on all credit card transactions.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such care to third party payors and/or other health practitioners (including but not limited to the family doctor).

I acknowledge that I have read the above authorization/release.

_____ _____

Patient's Signature or Legal Guardian **Date**

Person Responsible for payment and co-pay: _____

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HIPPA CONSENT FORM

Please print name _____

TEST RESULTS

I give my permission to release to the below named persons, any lab results, test results, medical records, or general medical information from my physicians, Dr. Nguyen or Dr. Roy.

NAME: _____

PRESCRIPTION

I give my permission for these named persons to pick up any prescription given to me by my physician, Dr. Nguyen or Dr. Roy.

NAME: _____

PHARMACY

I give my permission for Dr. Nguyen, Dr. Roy, and staff to call in prescriptions to my named pharmacy.

PHARMACY: _____

MINOR CHILD CONSENT

I, being the parent/guardian of: _____, do hereby request and authorized the medical staff to perform necessary medical services for my child, including but not limited to administration of anesthetics which are deemed advisable by the doctor whether-or-not I am present at the actual appointment when the treatment is rendered.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND PRACTICES

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" adopted by ENT & SINUS CENTER, P.C. I understand that if I have any questions about the "Notice of Privacy Practices," I may contact the Practice Compliance Officer at (909) 466-8400. The address of ENT & SINUS CENTER, P.C. is: 8241 Rochester Ave, Suite 130, Rancho Cucamonga, CA 91730.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE