JAMES J. LEE, M.D., F.A.C.S.
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NORTHERN ORANGE COUNTY ENT MEDICAL CORP

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PATIENT REGISTRATION

Patient Name________________________ ______________________ ______________Date:__________
Last First Middle

Address________________________________City_________________State__________Zip__________

Home Phone_______________________Cell Phone______________________D.O.B________Age____

E-Mail Address____

Marital Status: ❑ Single ❑ Married ❑ Minor Sex: ❑ M ❑ F

Social Security#_______________________________ Driver's License#___________________________

If minor, parent's SS#_____________________________If minor, parent's DL#____________________

Patient's employer (if minor, parent's employer)____

Address__________________________________City________________State________Zip__________

Guarantor Responsible Party: ❑ Self ❑ Other____________________ Relationship _____________

Emergency Contact: Name ______________________________________ Phone___________________

Source of referral: ❑ Doctor's Name____________________________Phone______________________

❑ Internet ❑ Insurance ❑ Family/Friend ❑ Other___________________

I hereby assign the insurance benefits to which I am entitled, directly to **James J. Lee, MD and /or John Y. Chew, MD.** I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

Signed____ Date____________________________
Patient or Guardian

At this time I do not have medical insurance. I agree to assume all financial responsibility.

Signed____ Date____________________________
Patient or Guardian