# Eric Waki MD, ENT Inc.

ERIC Y. WAKI, M.D. * MICHAEL KAO, M.D. * ERIC SUGIHARA, D.O.

## PATIENT INFORMATION

LAST NAME _____ FIRST NAME_____MI ____ AGE____ SEX_____ CELL PHONE_____

HOME ADDRESS_____ CITY_____ STATE_____ZIP_____

HOME PHONE_____DATE OF BIRTH_____SOCIAL SECURITY NUMBER XXX-XX-_____

(LAST FOUR ONLY)

OCCUPATION_____EMPLOYER_____WORK PHONE_____

SPOUSE'S NAME_____EMPLOYER_____WORK PHONE_____

Who may we share your medical information with? Name, Relationship & phone _____

_____WHAT IS YOUR EMAIL ADDRESS? _____

## INSURANCE INFORMATION

INSURANCE NAME_____SUBSCRIBER'S NAME_____DATE OF BIRTH_____

POLICY ID#_____SUBSCRIBER'S SOCIAL SECURITY NUMBER_____RELATION TO PATIENT_____

## REFERRAL INFORMATION

REFERRING DOCTOR OR PERSON REFERRED BY_____

PRIMARY CARE PHYSICIAN OR FAMILY DOCTOR_____PHONE NUMBER_____

## IF PATIENT IS A MINOR (All of this information must be completed)

DOES THE MINOR LIVE WITH BOTH PARENTS? YES NO

MOTHER'S NAME_____DATE OF BIRTH_____SSN_____HOME PHONE _____

ADDRESS_____CITY_____STATE_____ZIP CODE_____WORK PHONE _____

FATHER'S NAME_____DATE OF BIRTH_____SSN_____HOME PHONE_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____WORK PHONE_____

GUARANTOR OR LEGAL GUARDIAN_____DATE OF BIRTH_____SSN_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____HOME PHONE _____

WORK PHONE_____EMPLOYER_____OCCUPATION _____

IN CASE OF EMERGENCY CONTACT_____PHONE NUMBER _____RELATIONSHIP TO PATIENT _____

**IF MINOR DOES NOT LIVE WITH BOTH PARENTS PLEASE NOTE: ONLY THE PERSON(S) LISTED ABOVE WILL HAVE INFORMATION RELEASED TO THEM REGARDING THE MINOR.**

## AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE TREATMENT BY Eric Waki MD, ENT Inc. and its affiliated physicians.

I HEREBY AUTHORIZE PAYMENT OF SURGICAL OR MEDICAL BENEFITS, DIRECTLY TO Eric Waki MD ENT Inc. AND UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES. I ALSO AUTHORIZE Eric Waki MD ENT, Inc. AND ITS STAFF TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS.

IN THE CASE THAT THE INSURANCE CARRIER DENIES PAYMENT FOR ANY SERVICE, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE DUE.

WE ACCEPT CASH, CHECK OR CREDIT CARD. PLEASE NOTE THAT ANY RETURNED CHECK WILL BE CHARGED A $35.00 SERVICE FEE IN ADDITION TO THE AMOUNT OF THE CHECK.

SIGNATURE OF PATIENT_____DATE _____