Barry S. Tatar, M.D., LLC

PATIENT REGISTRATION

Social Security #:	**Primary Care Physician:**
Name:	**Marital Status:**
Address:	**Student: Yes No Full Time: Yes No**
City:	**Emergency Contact:**
State, Zip:	**Emergency Phone:**
Home Phone#:	**Emergency Contact Relationship:**
Work Phone#:	**Race:**
Cell Phone#:	**Ethnicity:**
Sex:	**Language:**
Date of Birth:	**Pharmacy:**
Employer:	**Full Time Employment: Yes No Retired: Yes No**
Email Address:	**Driver's License#:**
Referring Physician:	**Driver's License State:**

GUARANTOR INFORMATION (Financially Responsible Person)

Name:	**Date of Birth:**
Address:	**Social Security#:**
City:	**Employer:**
State, Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State, Zip:**
Cell Phone#:	**Relationship to Patient:**

INSURANCE INFORMATION (Insurance Policy Holder)

Primary Insurance:	**Secondary Insurance:**
Member#:	**Member#:**
Group#:	**Group#:**
Copay:	**Copay:**
Subsciber Name:	**Subscriber Name:**
Subscriber's Date of Birth:	**Subscriber's Date of Birth:**
Referral Required: Yes No	**Referral Required: Yes No**

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue treatment past your approved period, you will be responsible for your account balance in full.

I hereby authorize Barry S. Tatar, M.D., LLC, to release any information necessary for my course of treatment.

I have read the above policy regarding my financial responsibility to Barry S. Tatar, M.D., LLC for providing ENT service to the above named patient or me. I certify that the information provided is so, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Barry S. Tatar, M.D., LLC. I agree to pay Barry S. Tatar, M.D., LLC the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

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Signed (patient or parent if minor) Date