Westchase ENT & Facial Plastic Surgery

Janet I. Lee, M.D.

Patient Name: _____
First Middle Last

Address: _____
Street & Apt. # City State Zip

Age: _____ Birth date: _____ SS#: _____ Sex: ❑ Female ❑ Male

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: ❑Home ❑Work ❑Cell ❑Email Drivers License # : _____

Marital Status: ❑ Single ❑ Married to: _____ Email: _____

Patient Employer: _____ Occupation: _____

Primary Care Physicians: _____ Phone: _____

Referring Source: _____ Phone: _____

Emergency Contact: _____ Relationship To Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Health Insurance Company: _____ Phone # : _____

Policy # : _____ Group # : _____ Insured's Employer: _____

Referral Required: ❑ No ❑ Yes Copay ? : ❑ No ❑ Yes , $ _____ Relationship to Insured: _____

Insured Name: _____ DOB: _____ Social Security # : _____

Secondary Health Insurance Company: _____ Phone # : _____

Policy # : _____ Group # : _____ Insured's Employer: _____

Referral Required: ❑ No ❑ Yes Copay ? : ❑ No ❑ Yes , $ _____ Relationship to Insured: _____

Insured Name: _____ DOB: _____ Social Security # : _____

I acknowledge that all information that I have provided above is completely correct. I understand that office visit charges are payable on the day service is rendered. I understand that I am responsible for all self pay, deductible, coinsurance, copay, and non-covered service amounts. All unpaid balances over 30 days may be subject to a collection fees and interest charges of 1.5% per month. I authorize Dr. Janet Lee to bill my insurance company. I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical and surgical benefits to Dr. Janet Lee. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Janet lee and myself. I understand that there is an office policy in effect that for all returned checks there will be an additional $25.00 insufficient funds fee charged to me. I understand that all future scheduled appointments are subject to a $25.00 Non-Cancellation Fee, if appointment(s) are not adequately cancelled within 48hrs. prior to appointment date and time.

* **Signature:** _____ **Date:** _____