Mike S. Shin, M.D.
Ear, Nose, and Throat
Facial Plastic and Cosmetic Surgery

Date

Patient Information

Last	First	Initial
Address	City, State, Zip	
Home Phone	Cell Phone	Cell Phone Carrier
Email	Date of Birth	Age
Gender / Marital Status	Language Preference	
Race	Ethnicity	
Social Security Number	Driver License Number	
Occupation / Work Phone	Employer Name	
Employer Address	City, State, Zip	
Emergency Contact Name and Phone		
Referring Doctor	Primary Care Physician	

Guarantor Information (Person responsible for payment of the account)

Responsible Party Name	Relationship to Patient	
Street Address	City, State, Zip	
Home Phone	Cell Phone	Marital Status
Employer Name	DOB	
Employer Address		

Insurance Information

Primary Insurance Company	Name of Policy Holder	
Date of Birth	Relationship to Patient	
Subscriber's ID#/ SSN	Group Number	
Secondary Insurance Company	Name of Policy Holder	
Date of Birth	Relationship to Patient	
Subscriber's ID#/ SSN	Group Number	

Financial Agreement

I hereby authorize Dr. Mike S. Shin, M.D. to furnish my insurance company with all the information which they request concerning my present illness or injury. I request that payment of authorized benefits be made on my behalf for services provided to me by the party which accepts assignment. I understand that I am financially responsible to make prompt payments to the account of Dr. Mike S. Shin, M.D. as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection, I shall pay the actual attorney's fees and collection expenses. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that failure to make payment for any services not covered will result in my account being sent to Kings Credit Services.

X

Signature of Patient or Legal Guardian Relationship to Patient Date

I have been presented and given a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the notice, and subject to the following restriction(s) concerning my personal medical information. I agree to the disclosures named in the Notice: Notice of Privacy Practices of Mike S. Shin, M.D.

X

Signature of Patient or Legal Guardian Relationship to Patient Date