EDWIN TSENG, M.D. and JEFFREY TSENG, M.D.

Ear, Nose, Throat, Head & Neck Surgery and Facial Plastic & Reconstructive Surgery
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Telephone: (805) 496-8103

Patient's Name:______________________________ Date:______________

Date of Birth:______________________ Soc. Sec. #:______________________

Home Ph:____________ Cell Ph:______________ Work Ph: ____________

Occupation:______________________ Employer:______________________

Sex: M F Marital Status: M S W Spouse's Name:______________________

Home Address:____

City:______________________ State:__________ Zip:______________

Email Address:____

Emergency Contact:______________________________ Phone:______________

Referred by:______________________________ Phone:______________

Drug Allergies:____

Current Medications (include strength & dosing):______________________

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Primary Insurance Information

Policy Holder's (Subscriber) Name (First, Middle & Last):______________________

Policy Holder's Date of Birth:______________ Policy Holder's Soc. Sec. #:______________

Relation to Patient (Circle One): Self Spouse Parent Other Sex: M F

Policy Holder's Occupation:____________ Policy Holder's Employer:______________

Insurance Company:____

Member ID #:______________________ Group #:______________________

Secondary Insurance Information

Policy Holder's (Subscriber) Name (First, Middle & Last):______________________

Policy Holder's Date of Birth:______________ Policy Holder's Soc. Sec. #:______________

Relation to Patient (Circle One): Self Spouse Parent Other Sex: M F

Policy Holder's Occupation:____________ Policy Holder's Employer:______________

Insurance Company:____

Member ID #:______________________ Group #:______________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company

and assign directly to Edwin Tseng, MD and/or Jeffrey Tseng, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Parent/Guardian Signature:______________________________ Date:______________