



JAMES J. LEE, M.D., F.A.C.S.  
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**NORTHERN ORANGE COUNTY ENT MEDICAL CORP**

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**PATIENT REGISTRATION**

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ D.O.B \_\_\_\_\_ Age \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Marital Status:  Single  Married  Minor Sex:  M  F

Social Security# \_\_\_\_\_ Driver's License# \_\_\_\_\_

If minor, parent's SS# \_\_\_\_\_ If minor, parent's DL# \_\_\_\_\_

Patient's employer (if minor, parent's employer) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Guarantor Responsible Party:**  Self  Other \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Phone \_\_\_\_\_

**Source of referral:**  Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Internet  Insurance  Family/Friend  Other \_\_\_\_\_

I hereby assign the insurance benefits to which I am entitled, directly to **James J. Lee, MD and /or John Y. Chew, MD.** I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian

At this time I do not have medical insurance. I agree to assume all financial responsibility.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian