Shasta ENT Specialists

Redding SINUS Center

George H. Domb, MD
2125 Court Street
Redding, CA 96001
Phone: 530-242-5600
Fax: 530-242-5605

PLEASE COMPLETE ALL INFORMATION BELOW, THANK YOU. **Today's Date:** _____

Patient's Name: _____ **Gender:** ☐ Male ☐ Female
Last First MI

Patient Mailing Address: _____
Street / P.O. Box City State Zip Code

Best Phone #: _____ **Alternate #:** _____
☐ Home ☐ Cell ☐ Work ☐ Spouse ☐ Home ☐ Cell ☐ Work ☐ Spouse

Date of Birth: _____ **Social Security #:** _____

Email Address: _____ **Can we communicate with you via Email?** ☐ YES ☐ NO

Preferred Method of Communication: ☐ Home ☐ Cell ☐ Work ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____

If the patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ **Social Security #:** _____

Address (if different from above): _____
Street /P.O. Box City State Zip Code

Primary Insurance:

Insurance Company: _____

Policy # _____ Grp # _____

Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policy Holder: _____ DOB: _____

Secondary Insurance:

Insurance Company: _____

Policy # _____ Grp # _____

Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policy Holder: _____ DOB: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship to Patient:** _____

Best Phone #: _____ **Alternate #:** _____
☐ Home ☐ Cell ☐ Work ☐ Spouse ☐ Home ☐ Cell ☐ Work ☐ Spouse

PREFERRED PHARMACY: _____

I assign directly to *Dr. George H. Domb* any insurance benefits payable for service rendered. I understand that I am finacially responsible for all charges whether paid by my insurance or not. I authorize the release of information necessary to secure the payment of benefits.

Responsibility Party Signature: _____ **Date:** _____

Reviewed by Employee: _____

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Reviewed by Employee: _____