Children's Ear, Nose & Throat Specialists, PLLC

PATIENT REGISTRATION

Patient Name _____ Goes By _____
LAST FIRST MIDDLE

Address _____ SS# _____

City _____ State _____ Zip _____ Birth Date _____

Home # ( )_____ Cell ( )_____ Gender: M F Age _____

Has any family member been seen here before? Y N Name(s) _____

In Case of Emergency, please contact (someone not living with patient):

Name _____ Phone ( )_____ Relation _____

INSURANCE INFORMATION

Primary _____ Secondary _____

Policy ID # _____ Policy ID # _____

Group # (if applicable) _____ Group # (if applicable) _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Subscriber SS# _____ Subscriber SS# _____

Patient Relation to Subscriber_____ Patient Relation to Subscriber_____

PARENT/GUARDIAN RESPONSIBLE PARTY INFORMATION

Name _____ Relation to Patient _____ SS# _____

Address (if different from patient) _____ Phone # ( )_____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Employer _____ Work # ( )_____

Name _____ Relation to Patient _____ SS# _____

Address (if different from patient) _____ Phone # ( )_____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Employer _____ Work # ( )_____

I hereby authorize Children's Ear, Nose & Throat Specialists, PLLC (the "Practice") to furnish information to and obtain information from insurance carriers and other health care providers/facilities concerning my illness and treatments, consistent with the Privacy Notice provided. I acknowledge that I have been offered/received a Privacy Notice from the Practice. I hereby assign to the Practice all payments for medical and surgical services provided to me or my dependents. I understand that I am responsible for any charges not covered by insurance, managed care, government, or other provider. If my insurance company refuses payment, I understand that I am responsible for any charges incurred in the event that proper prior authorization for such services was not obtained. I understand that further non-emergent care may be denied if my account is not paid in full at the time of my office visit and/or surgery.

Signature _____ Date _____