

Acct: _____

PATIENT INFORMATION SHEET (CHILD AGE 17 AND UNDER)

Patient Name _____
Date of Birth _____
Social Security # _____ Male or Female
Address: _____

Phone Number _____
Parent's E-mail: _____

Referring Doctor: _____
Referring Doctor Phone _____
Family doctor/Pediatrician _____
Family doctor Phone _____
People authorized to receive Medical Information
(Name & Number) _____

Mother's Name _____
Address (if different): _____
_____ Phone _____
Date of Birth _____
Social Security # _____
Cell Phone: _____

Father's Name _____
Address (if different) _____
_____ Phone _____
Date of Birth _____
Social Security # _____
Cell Phone: _____

PRIMARY INSURANCE _____

Subscriber Name: _____
Policy ID# _____ Group _____
Employer: _____
Employer Address _____

Employer Phone _____
Co-Pay \$ _____

SECONDARY INSURANCE _____

Subscriber Name: _____
Policy ID# _____ Group _____
Employer: _____
Employer Address _____

Employer Phone _____
Co-Pay \$ _____

Has the child or any one else in the family been seen by our office before? YES – NO if yes, who? _____

Which Insurance is Primary, Mother's or Father's? (Please circle)

If the patient is a child under the age of 18, please list the guardians (who must be legal adults age 18 or older), other than the parents, who can seek medical treatment for this patient at our facility:

HIPAA: I have read and agree with the HIPAA Privacy information.

Financial Policy: I have read and understand the financial policy.

Insurance Authorization/Assignment

I hereby authorize ENT Head & Neck Specialists to release and/or obtain information to/from insurance carriers, other physicians, and/or medical facilities concerning my child's present illness/treatment and past medical history/treatment. I also hereby assign to the physicians of ENT Head & Neck Specialists all payments for medical services rendered to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature of parent _____ **Date** _____