

PATIENT INFORMATION SHEET (CHILD AGE 17 AND UNDER)

Patient Name _____

Male or Female

Social Security # _____

Referring Doctor: _____

Date of Birth _____

Referring Doctor Phone _____

Address: _____

Family Doctor/Pediatrician _____

Family Doctor Phone _____

Phone Number _____

Closest Living Relative (name and #) _____

Mother's Name _____

Father's Name _____

Address (if different) _____

Address (if different) _____

_____ Phone _____

_____ Phone _____

Date of Birth _____

Date of Birth _____

Social Security # _____

Social Security # _____

Cell Phone _____

Cell Phone _____

Mother's Insurance Carrier _____

Father's Insurance Carrier _____

Policy ID # _____ Group _____

Policy ID # _____ Group _____

Employer _____

Employer _____

Employer Address _____

Employer Address _____

Employer Phone _____

Employer Phone _____

Which insurance is primary Mother or Father? (please circle)

Since 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:

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** _____

PLEASE NOTE: Our office is not responsible for charges incurred if the updated insurance information is not provided for this patient.