ENT CARE for kids

Patient registration

Patient's name _____ Date _____ Male ☐ Female ☐

Address _____ City _____ State _____ Zip _____

Primary contact phone _____ SSN# _____ DOB _____

Referral information (How did you hear about us?)

Doctor ☐ Friend ☐ Hospital ☐ Insurance company ☐ Internet search ☐ Other patient ☐ Relative ☐ Yellow Pages ☐

Referred by _____ Phone _____

Primary physician/pediatrician _____ Phone _____

Parent/guardian information

Primary contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Mobile phone _____

Secondary contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Mobile phone _____

Insurance information (Financial guarantor)

Name _____ Driver's license # _____ Date of birth _____

Relationship _____ Employer _____ Insured's SSN# _____

Primary insurance _____ Phone _____

Group # _____ Policy # _____ Are you insured by HMO? Yes ☐ No ☐

Statement of financial responsibility

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize ENT Care for Kids to release any information necessary to process a claim for insurance benefits and authorize payment directly to the physician. Initial _____