The Ear Nose and Throat Clinic & Hearing Center
Pediatric Patient Registration

Account No.________________________ Date_____________________________
Patients Name_______________________________ Birthdate__________________________
Address________________________________ City_______________ State______ Zip_______
Social Security #_________________________ Sex M F Home Phone ( )_________________
Referring Physician_______________________ Referring Clinic_____________________________
If not referred, how did you hear about us?

☐ Friends/Family ☐ Insurance Company ☐ Yellow Pages ☐ Website ☐ Sign

☐ Other, (Please name)_______________________

Parent's Name_________________________
SSN___________________ DOB__________
Address_____________________________
City___________ State_______ Zip________
Home Phone________ Work Phone________
Email______________________________
Employer____________________________
Occupation___________________________

Second Parent's Name___________________
SSN_____________________DOB__________
Address_____________________________
City____________ State_______ Zip__________
Home Phone________ Work Phone__________
Email______________________________
Employer____________________________
Occupation___________________________

Emergency Contact_______________________ Phone ( )____________________________
Address________________________________ City_______________ State______ Zip_______
Relationship to Patient____

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name____________________
Insurance Company____________________
Address_____________________________
____
Phone ( )___________________________
Effective Date_________________________
ID/Contract#__________________________
Group/Plan#__________________________

Secondary Insurance

Policy Holder Name_______________________
Insurance Company_______________________
Address_____________________________
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Phone ( )___________________________
Effective Date_________________________
ID/Contract#__________________________
Group/Plan#__________________________

I authorize treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to The Ear, Nose and Throat Clinic and Hearing Center.
I authorize the release of correspondence and/or medical records to other medical providers involved in my child's care.
I have read and understand the Financial Policy.

Signature____Date____________________

Relationship____