Pediatric ENT, PLLC
New Patient Registration

Patient:

Last Name:____________________ First Name:____________________

Address:____

City:____________________ State:__________ Zip Code:__________

Home Phone: ( )____________________ Date of Birth:____________________

Email: ________________________________

Sex: M / F Social Security:____________________

Employed/School Grade:__________ School Name:____________________

Referring Physician:____________________Physician Phone: ( )__________

Employer:

Address:________________________________ City:____________________

State:__________ Zip Code:__________ Phone: ( )____________________

INSURANCE INFORMATION

Primary Insurance:________ Phone: ( )____________________

Ins #:____________________ Group #:____________________

Effective Date:____________________ Member #:____________________

RESPONSIBLE PARTY INFORMATION
(Person insurance is under)

Last Name:____________________ Initial:______ First:____________________

Date of Birth:____________________ Sex: M / F Social Security:____________________

Address:________________________________ City:____________________

State:________ Zip Code:__________ Phone: ( )____________________

Employer: Address:____________________ City:____________________

State:________ Zip Code:__________ Phone: ( )____________________

Nearest living relative or friend not living with you ________________________________
Relative/friend ____________________ Phone:( )____________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature:________________________________ Date:____________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature:________________________________ Date:____________________