ENT PARTNERS OF TEXAS
CHILD REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____

Sex: M / F (Circle one) Date of Birth: _____/_____/_____

Race/Ethnic Group _____ Preferred Language _____

Home Address:_____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Person(s) responsible for bill (if other than biological parents, please have legal documents available)

Parent/Guardian Name: _____ Social Security Number: _____ - ____ - _____

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____

E-mail Address: _____Drivers License # _____

Parent/Guardian Name: _____ Social Security Number: _____ - ____ - _____

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____
(Street) (City/Street/Zip)

E-mail Address: _____Drivers License # _____

Preferred Contact Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

Preferred Appt.Reminder Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

(PLEASE COMPLETE BACK SIDE OF THIS FORM)

Pediatrician: _____ Who Referred You: _____

Preferred Pharmacy: _____ Address: _____

FIRST INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

Who to call for an emergency:
Name: _____ Address:_____
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

MEDICATION HISTORY CONSENT
I authorize ENT Partners of Texas to obtain past medication history

SIGNATURE:_____DATE:_____

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION FOR BILLING
I authorize treatment of the person named above and agree to pay all fees for such treatment. I also authorize the release of any medical information necessary to process these claims. I hereby authorize ENT Partners of Texas to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Coordinator or Privacy Officer. My signature acknowledges my receipt of the Notice of Privacy Practices for ENT Partners of Texas.

SIGNATURE: _____ DATE: _____