ONSLOW
EAR NOSE & THROAT

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PEDIATRIC REGISTRATION FORM (PLEASE PRINT)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's full name:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address/ PO Box:			Social Security no.
Home Phone: ( )	City:	State:	ZIP Code
Father's Name	Social Security no.	Date of Birth	Business Phone ( )
Mother's Name	Social Security no.	Date of Birth	Business Phone ( )
Name of person not living with patient to contact for emergency			Phone:

Chose clinic because/referred to clinic by (Please check one box):	Dr.	☐ Insurance plan	☐Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	Other
Other family members seen here:			

INSURANCE INFORMATION

Primary Insurance Carrier Name	Policy ID			Group#
Insured's Name:	Soc. Sec. No (if not listed above):			Date of Birth (if not listed above)
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Other
Secondary Insurance Carrier Name	Policy ID			Group#
Insured's Name:	Soc. Sec. No (if not listed above):			Date of Birth (if not listed above)
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Other

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN

I give my permission for the physicians at Onslow Primary Care to provide any necessary medical care to my minor child whose name is:

Name of legal guardian/parent	Parent/Guardian Signature _____

REQUIRED SIGNATURE

I have been provided with the following documents from Onslow Primary Care: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice's website (www.onlsowprimarycare.org).

I authorize the release of information concerning my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, Inc. (For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Onslow Primary Care). I understand that I am personally responsible for all charges not covered by my insurance.

Parent/Guardian Signature _____ Date _____