ONSLOW
EAR NOSE & THROAT

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PEDIATRIC REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

Patient's full name:	Date of Birth:	Age:	Sex: ☐ M ☐ F Race:
Street address/ PO Box:			Social Security no.
City:	State:	ZIP code:	Home Phone:

Father's Name	Social Security Number	Date of Birth	Business Phone:
Father's Place of Employment:	Work Address:		Job Title:
Mother's Name	Social Security Number	Date of Birth	Business Phone:
Mother's Place of Employment:	Work Address:		Job Title:
Name of person not living with patient to contact for emergency			Phone:
Referred to clinic by:	Other family members seen here:		

INSURANCE INFORMATION

Primary Insurance Carrier Name	Policy ID	Group#
Insured's Name:	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Secondary Insurance Carrier Name	Policy ID	Group#
Insured's Name:	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 Ear Nose & Throat 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 Ear Nose & Throat: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice's website (www.onlsowent.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 Ear Nose & Throat). I understand that I am personally responsible for all charges not covered by my insurance.

Parent/Guardian Signature _____ Date _____