

Insurance cards copied
Date: _____

Child Registration Information

Account #: _____
Insurance #: _____
Co-Payment: \$ _____

Please PRINT AND complete ALL sections below!

PATIENT'S INFORMATION

Sex: Male Female

Name: _____
last name first name initial
Street address: _____ (Apt# _____) City: _____ State: _____ Zip: _____
Home phone: (_____) _____ Date of Birth: ____/____/____ Social Security # _____
month day year
Name of School: _____

RESPONSIBLE PARTY INFORMATION

Father's Name: _____ Date of Birth: ____/____/____ Social Security # _____
month day year
Address: _____ City: _____ State: _____ Zip: _____
Home phone: (_____) _____ Work phone: (_____) _____ Mobile phone: (_____) _____
Employer's Name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Date of Birth: ____/____/____ Social Security # _____
month day year
Address: _____ City: _____ State: _____ Zip: _____
Home phone: (_____) _____ Work phone: (_____) _____ Mobile phone: (_____) _____
Employer's Name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Cardholder Name: _____

PRIMARY Insurance Company's Name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____ Relationship to Insured: Self Spouse
 Other Child
Insurance ID Number: _____ Group Number: _____
SECONDARY Insurance Company's Name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____ Relationship to Insured: Self Spouse
 Other Child
Insurance ID Number: _____ Group Number: _____

PATIENT'S REFERRAL INFORMATION

Name of Physician that referred you: _____
PCP Name (If different than Referring Physician): _____

Assignment of benefits • Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to _____, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Parent/Guardian Signature: _____

Child Registration Information

Please PRINT AND complete ALL sections below!

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: (____) _____ Work phone: (____) _____ Mobile phone: (____) _____

PHARMACY PREFERENCE

Name: _____ Phone: _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

IRVING-COPPELL ENT FACSIMILE AUTHORIZATION FORM

The undersigned Patient/Guardian authorizes Irving-Coppell ENT to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories and other medical caregivers in the necessary coordination of care for the patient listed below.

Patient/Guardian may revoke this authorization by giving Irving-Coppell ENT five (5) days written notice. This revocation may be by facsimile transmission, however a **written copy of the revocation must be mailed to Irving-Coppell ENT as well.**

Patient Name: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Printed Name: _____

CONTACT AUTHORIZATION

Circle where you can be reached during business hours: Home Work Cell

May we contact you at home? Yes No

May we contact you at your place of business? Yes No

Leave message with:

Leave message with:

Yes No Voicemail / Answer Machine

Yes No Voicemail / Answer Machine

Yes No Mobile Phone

Yes No Mobile Phone

Yes No Family Member

Yes No Co-Worker

May we contact you via email? Yes No Email Address: _____

Patient Signature: _____

Parent/Guardian Signature: _____