

PATIENT REGISTRATION FORM for CHILD OR MINOR

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------|---------------|
| Patient's Name | | Date of Birth | Age |
| Address | | Home Phone # | Sex |
| City | ST | ZIP | Soc. Sec. No. |
| Parent's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed | | | |
| Mother's Name | | Date of Birth | Soc. Sec. No. |
| Mother's Address | | Phone Number | |
| May we contact you at work? | | Cell Phone | |
| Father's Name | | Date of Birth | Soc. Sec. No. |
| Father's Address | | Phone Number | |
| May we contact you at work? | | Cell Phone | |
| Personal Email address: | | | |

PARENTS EMPLOYER / WORK INFORMATION

| | | |
|-------------------|--|--------------|
| Mother's Employer | | Occupation |
| Address | | Work Phone # |
| Father's Employer | | Occupation |
| Address | | Work Phone # |

What Pharmacy do you use? Name _____ Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

DO YOU HAVE Group coverage through Mother's employer Group / Father's Employer
 Individual policy
 Other (Please List) _____

Please provide your policy information in the space below:

Insured _____
Insurance Company _____
Address _____
Insurance Supplement or Policy Number _____

PROCEDURE ADVISEMENT - Due to the nature of some of your or your dependent's presenting symptoms it is possible that the doctor will need to perform a diagnostic or therapeutic procedure in order to accurately and successfully diagnose and/or treat your or your dependent's condition. These services are billed separately and may be classified as surgery by some insurance carriers. Additionally, many primary sinus surgery procedures have planned and staged therapeutic post operative surgical procedures which are also separately billable, and are not included in the global fee for the primary surgery.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize Iowa ENT & Sinus Surgery Center, P.C. to release to the Medicare carrier and/or the insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I authorize payment of medial benefits to the above named Physicians/Clinic.

I understand that I am financially responsible for all charges incurred.

Date _____ Parent's Signature for Primary Insurance _____

Who may we thank for referring you: