



# PATIENT REGISTRATION FORM

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street Apt# City State Zip Code

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

Reason for Visit \_\_\_\_\_ Is patient allergic to any medications?  Y  N If yes, list \_\_\_\_\_

Referred by \_\_\_\_\_ Pediatrician \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Number \_\_\_\_\_

Name(s) of any siblings seen in this practice \_\_\_\_\_  
First Middle Last

I consent to being contacted by Email by providing the Email address \_\_\_\_\_

## INFORMATION BELOW IS NEEDED IN ORDER TO FILE INSURANCE

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Employer \_\_\_\_\_ Work # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Employer \_\_\_\_\_ Work # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Marital Status of Parents (Please check one)  Single  Married  Separated  Divorced  Other

Primary Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Relationship to Patient (Please check one)  Mother  Father  Step Parent  Foster Parent  Other

ID#/Contract# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Relationship to Patient (Please check one)  Mother  Father  Step Parent  Foster Parent  Other

ID#/Contract# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name \_\_\_\_\_

## PAYMENT IS REQUESTED WHEN YOUR VISIT IS COMPLETED.

I hereby authorize **Starfish Pediatric ENT, LLC (SPENTOC)** to obtain records from other sources as may be required in the treatment of this patient, to release information concerning this patient's treatment to other professionals involved in the care and treatment of this patient, and to release information to the insurance company as needed to file for charges incurred by this patient. I also agree that by signing this form, I authorize SPENTOC to release information concerning this patient to all persons whose names are listed above. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to

I understand that I am responsible for all charges incurred. A copy of this authorization shall be as valid as the original.

Concerning "divorce" or "custody" arrangements, SPENTOC regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

I also understand that it is the responsibility of the custodial party to obtain all referrals and that SPENTOC is not responsible for obtaining any referrals.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent or Responsible Party Relationship to Patient Date