



# BUCKHEAD ENT

## PATIENT INFORMATION FORM - MINORS

Under the age of 18 years old  
(Please Print)

Patient: \_\_\_\_\_ Nickname: \_\_\_\_\_  
          First                          Middle                          Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Is patient allergic to any medications? \_\_\_\_\_ If Yes, List: \_\_\_\_\_

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

Pharmacy Phone: \_\_\_\_\_ Pediatrician Phone: \_\_\_\_\_

Name(s) of any siblings seen in this practice: \_\_\_\_\_

I consent to being contacted by E-mail by providing E-mail Address: \_\_\_\_\_

### INFORMATION BELOW IS NEEDED IN ORDER TO FILE INSURANCE

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

**Primary Insurance Company:** \_\_\_\_\_ Employer: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured 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: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured Relationship to Patient (please check one):      Mother:  Father:  Step Parent:  Foster Parent:  Other:

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

### PAYMENT IS EXPECTED AT THE TIME OF VISIT

I hereby authorize Buckhead Ear, Nose and Throat 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 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 Buckhead Ear, Nose and Throat 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 Buckhead Ear, Nose and Throat. 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, Buckhead Ear, Nose and Throat 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 Buckhead Ear, Nose and Throat is not responsible for obtaining any referrals.

\_\_\_\_\_  
Parent or Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date