

PATIENT #: _____

Ear Nose and Throat Consultants of Nevada Patient History and Agreement-Minor

Patient: (please print)

Name (include middle initial) _____ Home Phone _____
Sex M F Date of Birth _____ Age _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Primary Care Physician _____ Referred By _____

Mother/Guardian:

Name (include middle initial) _____ Home Phone _____ Cell Phone _____
Sex M F Date of Birth _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Employer _____
Work Address _____ City _____ State _____ Zip _____
Work Phone _____ Email Address _____

Father/Guardian:

Name (include middle initial) _____ Home Phone _____ Cell Phone _____
Sex M F Date of Birth _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Employer _____
Work Address _____ City _____ State _____ Zip _____
Work Phone _____ Email Address _____

Insurance Information:

Primary Insurance _____ Subscriber _____
I.D. Number _____ Group Number _____ Phone _____
Claims Mailing Address _____

Secondary Insurance _____ Subscriber _____
I.D. Number _____ Group Number _____ Phone _____
Claims Mailing Address _____

Other Information:

Emergency Contact _____ Phone Number _____
Nearest relative not living with you _____ Phone Number _____

Financial Agreement and Authorization for Treatment

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services are charged to the patient. **The patient is responsible for all fees, regardless of insurance coverage.** In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

PATIENT SIGNATURE

DATE

GUARANTOR SIGNATURE

DATE

REGISTERED BY INITIALS