

SOUTHDALE OTOLARYNGOLOGY, PA
Pediatric Patient Registration

Account No. _____ Date _____
Patient's Name _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Gender M F Home Phone () _____
Referring Clinic _____ Referring Clinic _____

Mother's Name _____ Father's Name _____
SSN _____ DOB _____ SSN _____ DOB _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____
Employer _____ Employer _____
Occupation _____ Occupation _____

Emergency Contact _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Insurance Co _____	Insurance Co _____
Address _____	Address _____
_____	_____
Phone () _____	Phone () _____
Effective Date _____	Effective Date _____
ID/Contract # _____	ID/Contract _____
Group/Plan # _____	Group/Plan _____

I authorize medical treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to SOUTHDALE OTOLARYNGOLOGY, PA.
I authorize the release of correspondence and/or medical records to other medical providers involved in my child's care.
I have read and understand the Financial Policy.

Signature _____ Date _____
Relationship to Patient _____