Concord Otolaryngology
Alliance Audiology LLC

Account # _____
(for office use only)

CHILD REGISTRATION FORM

Today's Date _____ Referred by: _____ Primary Care Dr: _____

Last Name: _____ First: _____ Middle: _____ Nickname:_____

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other Social Security #:_____

Preferred Pharmacy: _____ Street: _____City: _____ Primary Language: ☐English ☐Other: _____

Race: ☐White ☐Black ☐Asian ☐Other ☐Declined Ethnicity: ☐Hispanic/Latino ☐Not Hispanic ☐Other ☐Declined

Address: _____Address 2: _____
If address is PO Box mailing address, include street address in Address 2

City: _____ State: _____ Zip _____ County: _____

Mother's Name: _____ Tel #: _____ / _____ / _____
Date of Birth: _____ Home Cell Work

Mother's Address: ☐Same ☐Other: _____ Employer: _____

Father's Name: _____ Tel #: _____ / _____ / _____
Date of Birth: _____ Home Cell Work

Father's Address: ☐Same ☐Other: _____ Employer: _____

Parent Email: _____@_____ *Optional*

Preferred Method of Communication: ☐Phone ☐Mail ☐E-Mail ☐Text ☐Portal

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance:_____
ID#: _____
Group Name or #_____
Policy Holder Name:_____
Policy Holder DOB:_____
Relationship to patient: ☐Father ☐Mother ☐Other_____
Policy Holder SSN #:_____

2) Secondary Insurance:_____
ID#: _____
Group Name or # _____
Policy Holder Name:_____
Policy Holder DOB:_____
Relationship to patient: ☐Father ☐Mother ☐Other_____
Policy Holder SSN #:_____

If NH Medicaid, please provide parent/guardian's Date of Birth: _____ ☐Father ☐Mother ☐Guardian

Medical or Billing Information regarding this child may be discussed with: ☐Mother ☐ Father ☐ Other: _____

I give permission for Concord Otolaryngology/Alliance Audiology to leave a message or appointment reminder for parent/guardians of this child at ☐ Home ☐ Cell Phone ☐ Employers # ☐ Other: _____

RELEASE OF INFORMATION: I hereby authorize Concord Otolaryngology/Alliance Audiology to release my dependent's medical records to any appropriate doctor, hospital, school nurse or other health related agency. I authorize the physicians to administer treatment or perform procedures deemed necessary in the diagnosis and treatment of my dependent's condition. I authorize taking of photographs for medical purposes if necessary.

Parent/Guardian Signature:_____ ____/____/_____ _____
Date of Birth Relationship