



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: _____ 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 #: _____ / _____ / _____
Home Cell Work

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

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

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

Parent Preferred Method of
Email: _____ @ _____ Communication: Phone Mail E-Mail Text Portal (Avail. Oct 2011)
Optional

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance: _____	2) Secondary Insurance: _____
ID#: _____	ID#: _____
Group Name or # _____	Group Name or # _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder DOB: _____	Policy Holder DOB: _____
Relationship to patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____	Relationship to patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other _____
Policy Holder SSN #: _____	Policy Holder SSN #: _____
If Healthy Kids Gold or Silver, please provide parent's DOB: _____ <input type="checkbox"/> Father <input type="checkbox"/> Mother	

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

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

RELEASE OF INFORMATION: I hereby authorize Concord Otolaryngology 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.

Patient or Parent/Guardian Signature: _____ Relationship _____

