

MINOR PATIENT INFORMATION

PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ **DATE OF BIRTH:** _____ / _____ / _____

ADDRESS: _____ **APT /UNIT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ - _____

HOME TEL: (____) _____ **ALTERNATE TEL:** (____) _____

SEX (Circle one): Male Female **LANGUAGE SPOKEN:** English Spanish **Other:** _____

PCP/REF PHYSICIAN: _____ **PHONE:**(____) _____ **FAX:**(____) _____

PHARMACY NAME: _____ **PHARMACY PHONE:** _____

RESPONSIBLE PARTY

GUARDIAN'S NAME: _____ **D.O.B:** _____

PATIENT LIVES WITH: _____ **EMAIL:** _____

MOM'S NAME: _____ **SOCIAL SECURITY NUMBER:** _____ - _____ - _____

ADDRESS IF DIFFERENT: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **EMPLOYER:** _____

WORK TEL #: _____ **ALTERNATE/CELL TEL #:** _____

DAD'S NAME: _____ **SOCIAL SECURITY NUMBER:** _____ - _____ - _____

ADDRESS IF DIFFERENT: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **EMPLOYER:** _____

WORK TEL #: _____ **ALTERNATE/CELL TEL #:** _____

HEALTH INSURANCE

*A photocopy of these assignments shall be valid as the original

***PRIMARY INSURANCE:** _____ **POLICY#** _____ **GRP#** _____

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S SS# _____ **RELATIONSHIP TO PT:** _____

***SECONDARY INSURANCE:** _____ **POLICY#** _____ **GRP#** _____

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S SS# _____ **RELATIONSHIP TO PT:** _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize South Florida ENT Associates, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to South Florida ENT Associates, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE _____ **DATE:** _____