PATIENT REGISTRATION FORM

PENTA
Pediatric ENT of Atlanta
Where Children Are First™

Patient Name _____ _____ _____ Nickname _____
First Middle Last

Address _____ _____ _____ _____ _____
Street Apt # City State Zip Code

Home Phone _____ - _____ - _____ Date of Birth _____/_____/_____ Sex ❍ Male ❍ Female

Reason for Visit _____ Is patient allergic to any medications? ❍ Y ❍ N If yes, list _____

Referred by _____ Pediatrician _____

Pharmacy Phone _____ - _____ - _____ Pediatrician Phone _____ - _____ - _____

Name(s) of any siblings seen in this practice _____ _____ _____
First Middle Last

I consent to being contacted by Email by providing the Email address _____

INFORMATION BELOW IS NEEDED IN ORDER TO FILE INSURANCE

Parent/Guardian Name _____ Relationship to Patient _____ DOB ____/____/_____

Parent/Guardian Employer _____ Work # ____ - ____ - _____ Cell #____ - ____ - _____

Parent/Guardian Name _____ Relationship to Patient _____ DOB ____/____/_____

Parent/Guardian Employer _____ Work # ____ - ____ - _____ Cell #____ - ____ - _____

Marital Status of Parents (Please check one) ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Other

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Primary Insurance Company _____ Employer _____

Insured's Name _____ Date of Birth ____/____/_____

Insured's Relationship to Patient (Please check one) ❍ Mother ❍ Father ❍ Step Parent ❍ Foster Parent ❍ Other

ID#/Contract# _____ Group# _____ Group Name _____

Secondary Insurance Company _____ Employer _____

Insured's Name _____ Date of Birth ____/____/_____

Insured's Relationship to Patient (Please check one) ❍ Mother ❍ Father ❍ Step Parent ❍ Foster Parent ❍ Other

ID#/Contract# _____ Group# _____ Group Name _____

PAYMENT IS REQUESTED WHEN YOUR VISIT IS COMPLETED.

I hereby authorize Pediatric Ear, Nose & Throat of Atlanta, P.C. (PENTA) to obtain records from other sources as may be required in the treatment of this patient, to release information concerning this patient's treatment to other professionals involved in the care and treatment of this patient, and to release information to the insurance company as needed to file for charges incurred by this patient. I also agree that by signing this form, I authorize PENTA to release information concerning this patient to all persons whose names are listed above. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to PENTA.

I understand that I am responsible for all charges incurred. A copy of this authorization shall be as valid as the original.

Concerning "divorce" or "custody" arrangements, PENTA regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

I also understand that it is the responsibility of the custodial party to obtain all referrals and that PENTA is not responsible for obtaining any referrals.

_____ _____ _____/_____/_____
Parent or Responsible Party Relationship to Patient Date