PATIENT #:______________

Ear Nose and Throat Consultants of Nevada
Patient History and Agreement-Minor

Patient: (please print)

Name (include middle initial) ______________________________ Home Phone ______________

Sex M F Date of Birth ____________ Age _______ Social Security Number ______________

Address ______________________________ City ____________ State _____ Zip __________

Primary Care Physician ______________________ Referred By ______________________

Race/Ethnicity ______________________________ Language ______________

Mother/Guardian: Cell Phone ______________

Name (include middle initial) ______________________________ Home Phone ______________

Sex M F Date of Birth ____________ Age _______ Social Security Number ______________

Address ____

City ______________________________ State ______________ Zip __________

Occupation ______________________ Employer ______________________________

Work Address ______________________________ City __________ State _____ Zip __________

Work Phone ______________________ Email Address ______________________________

Father/Guardian: Cell Phone ______________

Name (include middle initial) ______________________________ Home Phone ______________

Sex M F Date of Birth ____________ Age _______ Social Security Number ______________

Address ____

City ______________________________ State ______________ Zip __________

Occupation ______________________ Employer ______________________________

Work Address ______________________________ City __________ State _____ Zip __________

Work Phone ______________________ Email Address ______________________________

Insurance Information:

Primary Insurance ______________________ Subscriber ______________________

I.D. Number ______________ Group Number ______________ Phone ______________

Claims Mailing Address ____

Secondary Insurance ______________________ Subscriber ______________________

I.D. Number ______________ Group Number ______________ Phone ______________

Claims Mailing Address ____

Other Information:

Emergency Contact ______________________________ Phone Number ______________

Nearest relative not living with you ______________________ Phone Number ______________

Financial Agreement and Authorization for Treatment

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

PATIENT SIGNATURE ______ DATE ______ GUARANTOR SIGNATURE ______ DATE ______ REGISTERED BY INITIALS ______