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 _____