MIDWESTENTCENTRE
Breathe better. Hear better. Live better.

MINOR PATIENT REGISTRATION

Acct _____*MD*_____

Patient Name: _____
Last First M.I

Address: _____
Number Street City State Zip

Gender: M / F **Date of Birth:** _____/_____/_____ **Pt Social Security #** _____/_____/_____

PARENT /LEGAL GUARDIAN CONTACT INFORMATION

Mother Name: _____ **Father Name:** _____
Mother's # (_____)_____ **Father's # (_____)** _____

Email Address: _____

Please check preference: ☐ **You may leave a detailed message at the above numbers** ☐ **Do NOT leave a detailed message at the above numbers**

Name: _____ **Relationship to Patient:** ☐ **Parent** ☐ **Other** _____
(Person bringing patient today)

PERSON RESPONSIBLE FOR BILL

Guarantor Name _____**DOB:** _____/_____/_____**SSN:**_____/____/_____

Address:_____**Phone Number:** _____

***EMERGENCY CONTACT*: _____/*PH:*_____**

I authorize the RELEASE OF INFORMATION (medical record/financial information) to the following individuals_____ , _____

Pediatrician: _____ **Referring Doctor:** _____
First and Last Name **First and Last Name**

Primary Insurance

Insurance Name: _____ **DOB:** _____/____/_____ **SSN:** _____/____/_____

Subscriber Name: _____ **Relation to patient:** □ **Parent** □ **Grandparent** □ **Other** _____

Please provide address of the person who carries the policy ☐**Same as above**

Home Address: _____

Home # :(_____) _____ **Cell # :(_____)** _____

Secondary Insurance

Insurance Name: _____ **DOB:** _____/____/_____ **SSN:** _____/____/_____

Subscriber Name: _____ **Relation to patient:** □ **Parent** □ **Grandparent** □ **Other**_____

Please provide address of the person who carries the policy ☐**Same as above**

Home Address: _____

Home # :(_____) _____ **Cell # : (_____)** _____ ☐ **Additional insurance**

OVER

MIDWESTENTCENTRE
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AUTHORIZATION OF RELEASE OF INFORMATION / CONSENT TO TREATMENT / FINANCIAL RESPONSIBILITY

* **I am responsible for obtaining referrals as required by my insurance** for services rendered by Midwest ENT Centre, PC.
* **I am responsible for my insurance co-payment at the time services are rendered as well as any balance due after insurance has processed my claim(s).** If uninsured, I am responsible for all charges incurred at the time of my visit throughout my care.
* I hereby authorize, Midwest ENT Centre, PC, to release information necessary for my insurance company and/or Medicare to process my claim and to receive authorized direct payment of insurance benefits otherwise payable to me under the terms of my insurance.
* I understand that if my account is sent to collections, there is an additional 25% fee that will be incurred.
* I authorize Midwest ENT to send me education and/or marketing information on products and services. I understand I can revoke this authorization in writing at any time.
* I have completed this form and attest to the accuracy of all the information I have provided.
* **I authorize Midwest ENT Centre's physicians to render treatment to my minor child without my presence. I understand that surgery and/or testing may require a second visit with the parents or legal guardian present in the office.**

X _____ _____

Signature of Parent/Legal Guardian **Date**

Authorization to obtain medical records from your physician(s): I, _____ (Parent/Legal Guardian) hereby authorize the following physicians

_____

Physician(s) names that you previously have seen

_____

To release _____ (Patient Name) medical records including the diagnosis and records of any treatment or examination, including Test results, Audiograms/ENG, Sleep Study, CT Scan/MRI/Thyroid Ultrasound/FNA, Allergy Test Results, Pathology Reports, Operative Reports, lab results and reports rendered to me at any time to:

Midwest ENT Centre

4790 Executive Centre Pkwy

St Peters, MO 63376

Phone: 636-441-3100

Fax: 636-441-8072

_____

(PLEASE PRINT PARENT/LEGAL GUARDIAN NAME

X_____

Signature of Parent/Legal Guardian

COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION

5/31/2017 Thank you for choosing Midwest ENT Centre for your ear, nose and throat specialist.

Patient Name: _____Date:_____ MD _____

Below is a complete list of the medications that I am currently taking.

Please list each medication on a separate line.

MEDICATION NAME:	DOSAGE:	HOW OFTEN DO YOU TAKE IT ?
Example: Penicillin	*1 tablet*	*2x a day*

LIST ANY ALLERGIES TO MEDICATIONS:

_____