

**PATIENT REGISTRATION FORM for CHILD OR MINOR**

Patient's Name		Date of Birth	Age
Address		Home Phone #	Sex
City	ST	ZIP	Soc. Sec. No.
Parent's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed			
Mother's Name		Date of Birth	Soc. Sec. No.
Mother's Address		Phone Number	
May we contact you at work?		Cell Phone	
Father's Name		Date of Birth	Soc. Sec. No.
Father's Address		Phone Number	
May we contact you at work?		Cell Phone	
Personal Email address:			

**PARENTS EMPLOYER / WORK INFORMATION**

Mother's Employer	Occupation
Address	Work Phone #
Father's Employer	Occupation
Address	Work Phone #

**What Pharmacy do you use?** Name \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

DO YOU HAVE  Group coverage through Mother's employer  Group / Father's Employer  
 Individual policy  
 Other (Please List) \_\_\_\_\_

**Please provide your policy information in the space below:**

Insured \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Insurance Supplement or Policy Number \_\_\_\_\_

**PROCEDURE ADVISEMENT** - Due to the nature of some of your or your dependent's presenting symptoms it is possible that the doctor will need to perform a diagnostic or therapeutic procedure in order to accurately and successfully diagnose and/or treat your or your dependent's condition. These services are billed separately and may be classified as surgery by some insurance carriers. Additionally, many primary sinus surgery procedures have planned and staged therapeutic post operative surgical procedures which are also separately billable, and are not included in the global fee for the primary surgery.

**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS**

I authorize T. L. Wood, MD FACS to release to the Medicare carrier and/or the insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I authorize payment of medial benefits to the above named Physicians/Clinic.

**I understand that I am financially responsible for all charges incurred.**

Date \_\_\_\_\_ Parent's Signature for Primary Insurance \_\_\_\_\_

**Who may we thank for referring you:**