Patient Information

Last name _____ First name _____

Birthdate ____/____/_____ Age _____ Male _____ Female _____

Address _____ Apt # _____ City _____ State _____ Zip _____

If student, school attending _____

Referring physician _____ Phone (___)_____

Pediatrician/PCP _____

First Parent Last name _____ First name _____

Birthdate ____/____/_____ Texas Drivers Lic. # _____ Occupation _____

Phone (H) (___)_____ (W) (___)_____ (C) (___)_____

Employer _____ Email address _____

Second Parent Last name _____ First name _____

Birthdate ____/____/_____ Texas Drivers Lic. # _____ Occupation _____

Phone (H) (___)_____ (W) (___)_____ (C) (___)_____

Employer _____ Email address _____

Alternate Contact (when we cannot reach you) Name _____

Phone _____ Relationship to patient _____

Insurance Information – Please submit your insurance card and driver's license for copying

Primary Insurance_____ Verification Phone _____
ID # _____ Group plan # _____ Employer _____
Claims Address _____ City _____ State _____ Zip _____
Insured's Last Name _____ First Name _____ MI _____
Birthdate ____/____/_____ Texas Drivers Lic. # _____ Relationship to patient _____
Phone (H) (___)_____ (W) (___)_____ (C) (___)_____
Secondary Insurance_____ Verification Phone _____
ID # _____ Group plan # _____ Employer _____
Claims Address _____ City _____ State _____ Zip _____
Insured's Last Name _____ First Name _____ MI _____
Birthdate ____/____/_____ Texas Drivers Lic. # _____ Relationship to patient _____
Phone (H) (___)_____ (W) (___)_____ (C) (___)_____

"I hereby authorize Children's ENT of Houston/Mednax to provide any information associated with my care to my referring physician, other allied health professionals, or my insurance carrier."

Patient/Guarantor signature _____ Date _____