PENTA

Pediatric Ear, Nose & Throat of Atlanta, P.C.

PATIENT REGISTRATION FORM

404.255.2033

Putting Your Child First

Patient _____ _____ _____ Nickname _____
First Middle Last

Address _____ Apt.# _____ City _____ State ____ Zip _____

Home Phone ___–___–____ DOB ___–___–____ Sex ☐ M ☐ F

Reason for Visit _____ Is patient allergic to any medications? ☐ Y ☐ N if yes, list _____

Referred by _____ Pediatrician _____

Pharmacy Phone ___–___–____ Pediatrician Phone ___–___–____

Name(s) of any siblings seen in this practice _____ _____ _____
First Middle Last

I consent to being contacted by Email by providing the Email address _____

INFORMATION BELOW IS NEEDED IN ORDER TO FILE INSURANCE

Father's Name _____ DOB ___–___–____ SS# ___–___–____

Father's Employer _____ Work Phone ___–___–____ Cell Phone ___–___–____

Mother's Name _____ DOB ___–___–____ SS# ___–___–____

Mother's Employer _____ Work Phone ___–___–____ Cell Phone ___–___–____

Marital Status of Parents (Please check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other

---

Primary Insurance Company _____ Employer _____

Insured's Name _____ DOB ___–___–____ SS# ___–___–____

Insured's Relationship to Patient (Please check one) ☐ Mother ☐ Father ☐ Step Parent ☐ Foster Parent ☐ Other

ID#/Contract# _____ Group# _____ Group Name _____

Secondary Insurance Company _____ Employer _____

Insured's Name _____ DOB ___–___–____ SS# ___–___–____

Insured's Relationship to Patient (Please check one) ☐ Mother ☐ Father ☐ Step Parent ☐ Foster Parent ☐ Other

ID#/Contract# _____ Group# _____ Group Name _____

PAYMENT IS REQUESTED WHEN YOUR VISIT IS COMPLETED.

I hereby authorize Pediatric Ear, Nose & Throat of Atlanta, P.C. (PENTA) to obtain records from other sources as may be required in the treatment of this patient, to release information concerning this patient's treatment to other professionals involved in the care and treatment of this patient, and to release information to the insurance company as needed to file for charges incurred by this patient. I also agree that by signing this form, I authorize PENTA to release information concerning this patient to all persons whose names are listed above. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to PENTA. I understand that I am responsible for all charges incurred. A copy of this authorization shall be as valid as the original.

Concerning "divorce" or "custody" arrangements, PENTA regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

I also understand that it is the responsibility of the custodial party to obtain all referrals and that PENTA is not responsible for obtaining any referrals.

_____ _____ ___–___–____
Parent or Responsible Party Relationship to Patient Date

RESET FORM