

DR. _____

DATE: _____

CHILD'S REGISTRATION----E.N.T. ASSOCIATES OF GADSDEN

CHILD'S FULL NAME _____ NICKNAME CALL NAME _____ AGE _____
(LAST) (FIRST) (MI)

ADDRESS _____ SEX: M F
(Street/route/box) CITY STATE ZIP CODE

() DATE OF BIRTH _____
PHONE NUMBER MO. DAY YR. S.S. NUMBER RACE

PERSON TO CONTACT IN AN EMERGENCY/NOT LIVING WITH YOU ADDRESS/PHONE #

WHOM MAY WE THANK FOR THIS REFERRAL: _____

FAMILY DATA:

MOTHER

FATHER

	MOTHER	FATHER
NAME:		
DATE OF BIRTH:		
ADDRESS:		
EMPLOYER:		
POSITION HELD:		
WORK PHONE:		
HOME PHONE:		
SOCIAL SECURITY NUMBER:		

I understand that I am totally responsible for payment of all expenses incurred. I assign and authorize E.N.T. ASSOCIATES OF GADSDEN payment of any and all benefits payable by insurance, and the necessary release of medical information needed to process any insurance claims. I further agree, in the event of non-payment, to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 33-1/3% of the unpaid balance. The undersigned waives the rights of exemption under the laws of the State of Alabama. **PAYMENT IS REQUESTED AT TIME OF SERVICE.**

I, the undersigned, give permission for E.N.T. ASSOCIATES OF GADSDEN to render medical treatment to the above child.

SIGNED PATIENT/RESPONSIBLE PARTY

DATE