



Account # _____
(for office use only)

CHILD REGISTRATION FORM

Today's Date _____ Referred by: _____ Primary Care Dr: _____

Last Name: _____ First: _____ Middle: _____ Nickname: _____

Date of Birth: _____ Sex: Male Female Other Social Security #: _____

Preferred Pharmacy: _____ Street: _____ City: _____ Primary Language: English Other: _____

Race: White Black Asian Other Declined Ethnicity: Hispanic/Latino Not Hispanic Other Declined

Address: _____ Address 2: _____
If address is PO Box mailing address, include street address in Address 2

City: _____ State: _____ Zip _____ County: _____

Mother's Name: _____ Tel #: _____ / _____ / _____
Date of Birth: _____ Home Cell Work

Mother's Address: Same Other: _____ Employer: _____

Father's Name: _____ Tel #: _____ / _____ / _____
Date of Birth: _____ Home Cell Work

Father's Address: Same Other: _____ Employer: _____

Parent Preferred Method of
Email: _____ @ _____ Communication: Phone Mail E-Mail Text Portal
Optional

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance: _____ 2) Secondary Insurance: _____

ID#: _____ ID#: _____

Group Name or # _____ Group Name or # _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Relationship to patient: Father Mother Other _____ Relationship to patient: Father Mother Other _____

Policy Holder SSN #: _____ Policy Holder SSN #: _____

If NH Medicaid, please provide parent/guardian's Date of Birth: _____ Father Mother Guardian

Medical or Billing Information regarding this child may be discussed with: Mother Father Other: _____

I give permission for Concord Otolaryngology/Alliance Audiology to leave a message or appointment reminder for parent/guardians of this child at Home Cell Phone Employers # Other: _____

RELEASE OF INFORMATION: I hereby authorize Concord Otolaryngology/Alliance Audiology to release my dependent's medical records to any appropriate doctor, hospital, school nurse or other health related agency. I authorize the physicians to administer treatment or perform procedures deemed necessary in the diagnosis and treatment of my dependent's condition. I authorize taking of photographs for medical purposes if necessary.

Parent/Guardian Signature: _____ / / _____
Date of Birth Relationship