ONSLOW
EAR NOSE & THROAT

55 Office Park Drive · Jacksonville, NC 28546
Phone: 910.219.3377 · Fax: 910.219.4227

PEDIATRIC REGISTRATION FORM (PLEASE PRINT)

PEDIATRIC REGISTRATION

PATIENT'S FULL NAME:	DATE OF BIRTH:	AGE:	SEX: oM oF RACE:
STREET ADDRESS:	SOCIAL SECURITY #		
CITY: / STATE: / ZIP CODE:	HOME PHONE:		
FATHER'S NAME: / SOCIAL SECURITY: / DATE OF BIRTH:	BUSINESS /CELL PHONE:		
FATHER'S PLACE OF EMPLOYMENT: / WORK ADDRESS:	JOB TITLE:		
MOTHER'S NAME: / SOCIAL SECURITY: / DATE OF BIRTH:	BUSINESS/CELL PHONE:		
MOTHER'S PLACE OF EMPLOYMENT: / WORK ADDRESS	JOB TITLE		
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:	PHONE:		
REFERRED TO CLINIC BY:			

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME:	POLICY ID/TRICARE SPONSOR SOCIAL SEC #	GROUP # /TRICARE SPONSOR D.O.B
INSURED'S NAME:	PATIENTS RELATIONSHIP TO SUBSCRIBER: ○SELF ○SPOUSE ○CHILD ○OTHER	
SECONDARY INSURANCE CARRIER NAME:	POLICY ID/ TRICARE SPONSOR SOCIAL SEC #	GROUP # / TRICARE SPONSOR D.O.B.
INSURED'S NAME:	PATIENTS RELATIONSHIP TO SUBSCRIBER: ○SELF ○SPOUSE ○CHILD ○OTHER	

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN

I GIVE MY PERMISSION FOR THE PHYSICIANS AT ONSLOW EAR, NOSE AND THROAT TO PROVIDE ANY NECESSARY MEDICAL CARE TO MY MINOR CHILD WHOSE NAME IS:

NAME OF LEGAL PARENT/GUARDIAN:	PARENT /GUARDIAN SIGNATURE:

REQUIRED SIGNATURE

I have been provided with the following documents from Onslow Ear, Nose & throat: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice's website (www.onslowent.org).

I authorize the release of information concerning my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for the insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, Inc. (for Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Onslow Ear, Nose and Throat). I understand that I am personally responsible for all charges not covered by my insurance.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Patient Portal allows you to have access to Appointments, Lab results, Medication refill, Medical Records and more.

If you are interested please provide your EMAIL below:

E-Mail: _____

NAME:	DATE OF BIRTH

ALLERGIES (MEDICATIONS, X-RAY DYES, LATEX) *PLEASE STATE TYPES OF REACTION

PRESCRIPTION MEDICATIONS – NAME, DOSAGE ○SEE LIST		

PEDIATRIC PATIENT EXPOSED TO SMOKE? ○ NO ○ YES
13 YEARS AND OLDER *DOES PATIENT SMOKE* ○ NO ○ YES

PAST MEDICAL HISTORY	*PREGNANT OR THINK YOU MAY BE PREGNANT ○YES ○NO			
○ ACID REFLUX (GERD)	○ BIRTH DEFECT	○ DEVELOPMENTAL DELAY	○ KIDNEY DISEASE	○ SLEEP APNEA
○ ANEMIA	○ BLEEDING/CLOTTING DISORDER	○ DIABETES	○ LIVER CIRRHOSIS	○ STROKE/TIA
○ ANXIETY	○ CANCER TYPE:	○ HEART DISEASE	○ MIGRAINES	○ THYROID DISORDER
○ ASTHMA	○ COPD/EMPHYSEMA	○ HIGH BLOOD PRESSUSE	○ SEASONAL ALLERGIES	○ TINNITUS
○ AUTOIMMUNE DISODER	○ DEPRESSION	○ INSOMNIA	○ SEIZURES	○ VERTIGO/DIZZINESS
PAST HOSPITALIZATION	MONTH	YEAR	REASON:	

PAST SURGICAL HISTORY				
○ EAR TUBES	○ SEPTOPLASTY	○TYMPANOPLASTY	○ HEAD/NECK CANCER SURGERY	○ EYE SURGERY
○ TONSILLECTOMY	○ TERBINATE	○ MASTOID SURGERY	○ HEART SURGERY	○ OTHER:
○ ADNOIDECTOMY	○ SINUS SURGERY	○ SLEEP APNEA SURGERY	○ PACEMAKER PLACEMENT	

FAMILY HISTORY ○ADOPTED (PLEASE SKIP THIS SECTION) *PLEASE ONLY LIST BLOOD RELATED FAMILY				
	FATHER	MOTHER	SIBLING(S)	CHILD(REN)
ANESTHESIA PROBLEM				
BLEEDING/CLOTTING DISORDER				
CANCER/LIST TYPE				
HEART DISEASE				
HEARING DISORDER				
OTHER				

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU:		
EAR PROBLEMS	**NOSE PROBLEMS**	**THROAT PROBLEMS**
○ EAR ACHE ○RIGHT ○LEFT	○ STFFINESS/BLOCKAGE	○ SORE THROAT
○ DIZZINESS/VERTIGO	○ POSTNASALDRIP/RUNNY NOSE	○ SWOLLEN GLANDS
○ INJURY TO EAR	○ NOSE BLEEDS	○ HOARSENESS
○ EAR DRAINAGE	○ SNORING	○ COUGHING UP BLOOD
○ HEARING LOSS ○GRADUAL ○SUDDEN	○ LOSS OF SMELL	○ DIFFICULTY SWALLOWING
○ RINGING IN EARS	○ SNEEZING	○ BAD BREATH
○ OTHER	○ OTHER	○ OTHER

Onslow Ear Nose & Throat

PATIENT/INSURED AGREEMENT

In an effort to provide clear communication with our patients, please be advised as follows:

- The contractual agreement for your medical benefits is between you and the insurance company. We provide billing as a courtesy.
- For all insurance companies that we have a contractual agreement with, we will accept the "In-Network" benefits as outlined on the individual Explanation of Benefits. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all insurance companies that we *DO NOT* have a contractual agreement with, we will accept the "Out-of-Network" benefits, if such benefits are available. You (the patient/insured) will still be responsible for any and all co-pays, deductibles or coinsurance amounts due in accordance with the Explanation of Benefits.
- For all non-contracted insurance companies, you (the patient/insured) will be responsible for all charges in accordance with Onslow Ear Nose & Throat "Private Pay" fee schedule.
- When insurance benefits have been exhausted and/or terminated, you (the patient/insured) will be responsible for the charges incurred in accordance with Onslow Ear Nose & Throat "Private Pay" fee schedule.
- We cannot verify if all services/modalities will be covered by a particular benefit plan. *THIS IS YOUR (THE PATIENT/INSURED'S) RESPONSIBILITY!*
- In all cases, you (the patient/insured) will be responsible for any non-covered services, deductibles, co-pays and coinsurance amounts deemed as patient responsibility by your insurance company.

THIS AGREEMENT SUPERSEDES ALL OTHER VERBAL AGREEMENTS

I have read and agree to be financially responsible for all services both COVERED and NON COVERED by my insurance company.

_____ _____

SIGNATURE DATE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note if you wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information such as test results (including HIV/AIDS), pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time..

Patient Name:_____ Date of Birth:_____

Do NOT release information about:_____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name: _____

Relationship to patient: _____

Contact phone number: _____

Signature: _____ Date Signed:_____

PHONE RELEASE

I authorize Onslow Ear, Nose and Throat to leave a message with anyone that answers my phone or on my answering machine in regards to any up coming appointments, or issues in regard to my care.

Signature: _____ Date Signed:_____

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Pre-Authorization for Medical Care to Children

In the event that you are unable to accompany your minor child to an office visit please provide the name(s) of individual(s) eligible to authorize medical care for your child.

NAME	PHONE #	RELATIONSHIP TO CHILD

Please review the following authorization for treatment and complete the information if you wish to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize **Onslow Ear Nose and Throat** and its personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT

Today's Date: _____

Childs Name: _____ Childs date of birth: _____

Parent/guardian Name:_____ Relationship to child: _____

Telephone number: Home: _____ Cell: _____ Work: _____

Signature of parent or guardian: _____

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No Show/ Cancellation Policy

Due to the number of patients requesting specific appointment times at Onslow Ear, Nose and Throat our No Show/ Cancellation Policy is:

You will be charged a **$25.00** No Show/Cancellation fee if:

- You do not call to cancel **24 hours** prior to your appointment
- You do not check in at front before your appointment time (you should plan to be here 15 minutes before your appointment time to complete paperwork)
- In order to ensure our schedule remains on time, if you are **10 minutes** late for your appointment, **YOU WILL BE RESCHEDULED.**
- You may call our office at (910) 219-3377 and leave a message to cancel your appointment. Our answering service WILL place a time stamp on your message.
- Having THREE (3) No Shows within a six month period, beginning from the date of the first No Show **may prevent you from being able to schedule further appointments.**

Our main goal is to provide excellent patient care and customer service so we thank you for your understanding in this matter.

_____ _____

Signature Date

_____ _____

Witness Date

Patient has refused to sign_____

PATIENT UNDERSTANDS THAT REGARDLESS OF SIGNATURE THEY WILL BE CHARGED A $25.00 NO SHOW/CACELLATION FEE THROUGH MED BILL.

Onslow ENT Office Staff