NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Rd, Ste A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

PEDIATRIC/TEEN PATIENT REGISTRATION Today's Date _____

Patient Name _____ Date of Birth ___/____/____ Age ___(yrs) ___ (mos)

Parent/Guardian Phone Numbers: H _____ W _____ Cell _____

Street Address _____ City_____ Zip_____

Email Address _____ Patient Social Security # _____

Emergency contact name and phone number: _____

Preferred Language _____ Interpreter name and phone number_____

Can we leave voice mail messages with health information at the above number(s) and relay health information

(such as test results) to whomever answers at the above number(s)? Yes____ No____

Referring Provider _____ **Primary Care Provider** _____

Insurance information

Primary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth: _____ Employer _____

Secondary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth:_____ Employer _____

Insurance preferred lab _____ Insurance preferred radiology facility_____

Release/Assignment/Acknowledgement

I hereby authorize North County Ear, Nose and Throat, Head and Neck Surgery, Inc. to release pertinent information to other health care providers involved in my dependent's care and/or insurance companies holding policies on my dependent.
I authorize my insurance company to directly remit payment to North County Ear, Nose and Throat, Head and Neck Surgery, Inc. for medical and surgical services provided.
I understand that I am ultimately responsible for all charges incurred. It is my responsibility to know my insurance and make sure that if I am using an HMO my dependent has an authorization from their primary care doctor and/or insurance company to see this doctor.

I understand that by not providing the office with all information requested and/or copies of my insurance card(s) at the time of service, this could delay the processing of my claim and I could be personally responsible for payment of these services.
Notice to consumers: I understand that medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbca.gov
Privacy Notice Record-I acknowledge that I have received a copy of the Notice of Privacy Practices. My signature below indicates my acceptance/understanding of the above statements.

Signature of parent or legal guardian_____ Date _____

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PEDIATRIC/TEEN PATIENT MEDICATION FORM Today's Date _____

1. Patient Name: _____ **Date of Birth** ___/____/____

2. Pharmacy information: Please list the name, phone number and address of your preferred **pharmacy**:

Pharmacy name: _____ Phone Number: _____

Street Address: _____ City_____ ZIP Code _____

3. Medications: Please list **all** medications your child is currently taking (including herbal supplements, vitamins, aspirin, nasal sprays, other "over-the-counter" medications, etc.) and **dosage:**

Check here if none ☐

Medication	**Dosage**	**Medication**	**Dosage**

4. Allergies: Please list any allergies and the type of reaction (include medications, latex, xray dye, food, environmental):

Check here if none ☐
