

(Please PRINT clearly and complete all blanks.)



**Child's Information**

**Randall Cohen MD**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security# \_\_\_\_\_ Referred By \_\_\_\_\_

Pediatrician's Name \_\_\_\_\_ Pediatrician's Phone Number \_\_\_\_\_

**Guarantor's Information**

Responsible Person \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone/Other \_\_\_\_\_

**Insurance Information**

Name of Insurance Company \_\_\_\_\_

Insurance address \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Copay Amount \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

**Statement of Insurance Assignment**

I hereby assign, transfer and set over to Catalina Ear Nose and Throat PC all my rights, titles and interests to my medical reimbursement benefits under insurance policies. I am financially responsible for the charges incurred apart from those contracted through my insurance company, including the balance remaining after payment of possible insurance benefits. Should my account be delinquent and referred for collection I will be held responsible for all costs of collections, attorney's fees, and court costs resulting from such actions. I permit a copy of this authorization to be used in the place of the original. My signature below shall be valid for the course of my treatment.

**Release of Medical Records**

I authorize release of medical records and/or studies to Catalina Ear Nose & Throat PC from any source for evaluation and care. I also authorize release of medical information necessary to process my claims.

Parent Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_