EARS of Ardmore, Inc.
1505 N. Commerce Ste 111
Ardmore, Ok 73401

PEDIATRIC INFORMATION

(Please Print)

Patient's Name: ________________________________ Phone:____________

Nickname: _________Male_______Female______Social Security Number:__________

Address: ____
City State Zip

Date of Birth:______________ Age:________ Grade:____________

Mother's Name:______________________ Occupation:____________________

Father's Name:______________________ Occupation:____________________

Responsible Party:

Name:___________________________________ Phone:____________________

Address:____
City State Zip

Relationship to Patient:________________Social Security Number:______________

Insurance Information:

Name of Insured:_____________________Social Security Number:______________

Please be sure to have the receptionist photocopy your insurance card for billing purposes.

Nearest Relative (not living in same home):__________________Phone:____________

Address:____
City State Zip

Primary/Referring Physician:____________________________Phone:____________

Address:____
City State Zip

I AUTHORIZE THE RELEASE OF INFORMATION TO THE APPROPRIATE MEDICAL FACILITIES, PROFESSIONAL AGENCIES, AND INSURANCE COMPANIES AS DEEMED NECESSARY. I UNDERSTAND THIS IS CONSIDERED A LEGAL DOCUMENT.

______________________________Signature ______________Date