Insurance Information & Responsible Party

Kids ENT of Indiana

Patient Last Name _____ **DOB** _____

Primary Insurance Carrier: _____

Subscriber Name _____ _____ _____
Last M.I. First

Subscriber Date of Birth _____

Subscriber SSN _____

Member ID No. _____ Group No. _____

Subscriber Relationship to Patient □Self □ Father □ Mother □Other

Secondary Insurance Carrier: _____

Subscriber Name _____ _____ _____
Last M.I. First

Subscriber Date of Birth _____

Subscriber SSN _____

Member ID No. _____ Group No. _____

Subscriber Relationship to Patient □Self □ Father □ Mother □Other

Responsible Party

Name _____ _____ _____
Last M.I. First

Address □ Same as Patient _____ _____ _____ _____
Street City State Zip

Date of Birth _____

Email _____

**statements may be mailed, emailed, and/or sent via text

_____
Signature

I give Kids ENT of Indiana, LLC consent to treat patient, bill for services, and aware of HIPAA Rules and Regulations.