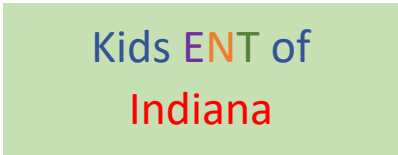


Insurance Information & Responsible Party



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.