Kids ENT of Indiana

Patient Information

Date _____

Patient Name _____ (Last) _____ (M.I.) _____ (First)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Date of Birth _____ Male ☐ Female ☐

Contact

	Primary	Secondary
Name		
Relationship		
Cell Phone		
Home Phone		
Other Phone		
Email		
Granted Full PHI Access (Patient Health Information)	Yes ☐ No ☐	Yes ☐ No ☐

☐ Initial

By initialing you consent to Kids ENT leaving a voicemail message at the numbers indicated above and/or discussing the individual listed above related to ENT treatment. These communications may include but are not limited to appointment reminders, medications, registration, billing and insurance items, and any information pertaining to otolaryngotomy treatment. Information may also be communicated via text, email, and/or direct mail.

Preferred Contact Method ☐ Phone ☐ Text ☐ Email