Santa Barbara ENT
Rebecca D. Golgert, M.D.
2420 Castillo Street, Suite 100
Santa Barbara, CA 93105
Tel: (805) 563-1999 Fax: (805) 563-4999

PEDIATRIC DEMOGRAPHIC FORM

PATIENT INFORMATION

Name _____ Sex *M* *F* DOB: _____
Last *First* *Middle*

Address _____
Street or PO Box *City* *State* *Zip*

Home Phone Number: (_____)_____ Who is accompanying the child today? _____

Mother's Name: _____ Father's Name: _____

Address (*if different*): _____ Address (*if different*): _____

Cell phone: (_____)_____ Cell Phone: (_____)_____

Email: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Who may we share the child's medical information with? Mother Father Both

Who is the pediatrician? _____ Office Phone number: (_____)_____ Last visit: _____

PRIMARY INSURANCE

Please provide valid picture ID and Insurance card(s) to front desk to be copied.

Insurance company _____ Member# _____ Group#_____

Person responsible for account if not the patient _____ Birth Date _____

Relationship to Patient _____ Social Security# _____-_____-_____

Address (*if different from patient's*) _____

Person responsible is employed by_____

ADDITIONAL INSURANCE

Insurance company _____ Member# _____ Group#_____

Person responsible for account if not the patient _____ Birth Date _____

Relationship to Patient _____ Social Security# _____-_____-_____

Address (*if different from patient's*) _____

Person responsible is employed by_____

FINANCIAL AGREEMENT AND RELEASE

I hereby authorize my child's insurance benefits be paid directly to Santa Barbara ENT, realizing that I am responsible for all co-pays, deductibles, co-insurance and any non-covered service balances. I understand that I am financially responsible for charges whether or not they are covered by insurance. I am responsible for contacting my insurance provider directly to confirm benefits and coverage. I authorize the doctor's office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Parent Signature: _____ Date _____

Parent Name *(printed)*: _____