Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

PATIENT INFORMATION (CHILD)

Chart: _____

**EMAIL COMPLETED FORMS TO: SCHEDULING@ENTLUBBOCK.COM

Last Name | First Name | Middle Name | Suffix

Date of Birth | ☐ male ☐ female | SS# | Preferred Language (s)

Street /Mailing Address | City | State | 9 Digit Zip Code

Preferred Phone (with Area Code) | May we contact you via email? ☐ No ☐ Yes

Email Address: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Race: ☐ Native American/Alaskan ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined

Father/ Guardian Name	Mother/ Guardian Name
Date of Birth / SS# / ☐ Insured	Date of Birth / SS# / ☐ Insured
Street Address / ☐ Responsible Party	Street Address / ☐ Responsible Party
City / State / Zip	City / State / Zip
Home Phone (with Area Code)	Home Phone (with Area Code)
Cell Phone (with Area Code) / ☐ Full Custody	Cell Phone (with Area Code) / ☐ Full Custody
Work Phone (with Area Code)	Work Phone (with Area Code)
Employer / ☐ Joint Custody	Employer / ☐ Joint Custody
Employer's Street Address	Employer's Street Address
City / State / Zip	City / State / Zip

Allergies to Medications

Referring Physician | Phone

Family / Primary Physician | Phone

Pharmacy | Location | Phone

Emergency Contact Other Than Parent or Guardian | Relationship | Phone

Payment of Fees

If the patient is a minor, the person(s) scheduling and accompanying the patient to the appointment will be the responsible party and therefore is responsible for all payments. By signing this form, I indicate that I understand my patient responsibility as outlined in the Ear Nose and Throat Associates Financial Policy (copy available at www.entlubbock.com or upon request). Fees are due and payable at the time services are rendered, unless other arrangements have been made in advance with our office manager. I also understand that my account may be referred to collections if balances are not paid in full.

Insurance Authorization & Assignment

I hereby authorize Ear Nose & Throat Associates of Lubbock, P.A. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services performed by this office and rendered to myself or my dependents. In the event that payment must be issued to the policy holder as stated in my contract, I authorize this payment be mailed to the provider of services. I understand that I am responsible for any amount not covered by insurance.

Signature _____ **Date** _____

(If completing online, you may submit unsigned form and then sign upon arrival)