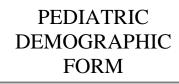


Santa Barbara ENT Rebecca D. Golgert, M.D. 2420 Castillo Street, Suite 100 Santa Barbara, CA 93105 Tel: (805) 563-1999 Fax: (805) 563-4999



## PATIENT INFORMATION

Name	$\qquad \qquad $
	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 ( <i>if different</i> ):	Address (if different):
Cell phone: ()	Cell Phone: ()
Email:	Email:
Marital Status: Single Married Partnered Divorced Separated Widowed Who may we share the child's medical information w	Divorced Separated D Widewed
Who is the pediatrician? Office I	Phone number: () Last visit:
PRIMARY INSURANCE	
Please provide valid picture ID and Insurance card(s) to front desk to be copied.	
Insurance company Me	ember# 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 Me	ember# 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	
responsible for all co-pays, deductibles, co-insurance am financially responsible for charges whether or	e paid directly to Santa Barbara ENT, realizing that I am e and any non-covered service balances. I understand that not they are covered by insurance. I am responsible for n 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):