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Ear, Nose & Throat Specialist  
Facial & Plastic Reconstructive Surgery

**CHILD PATIENT INFORMATION**

Today's Date: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Preferred or nickname: \_\_\_\_\_  
(last name) (first name) (MI)

Patient: Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_  
(last name) (first name) (MI)

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_ EXT \_\_\_\_\_

D.O.B: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_  
(last name) (first name) (MI)

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_ EXT \_\_\_\_\_

D.O.B: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Whom does the child live with? \_\_\_\_\_ whom is responsible for child's medical expenses? \_\_\_\_\_

Home Address (if different than patient's): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient's primary care physician: \_\_\_\_\_

Emergency notification (other than guardian): \_\_\_\_\_

**INSURANCE INFORMATION (we will copy your insurance card if you have it)**

Name of Subscriber (if other than patient): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscriber's birth date: \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Subscriber's business phone #: \_\_\_\_\_

Insurance Company name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

ID#, Policy, or Recipient #: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Subscriber (if other than patient): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscriber's birth date: \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_

Insurance Company name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

ID#, Policy, or Recipient #: \_\_\_\_\_ Group #: \_\_\_\_\_

*As a courtesy to you, our staff will help you file your insurance forms. We do not charge you for performing these tasks and they are not part of the medical services we render to you. Accordingly, we cannot be responsible for errors of delay in filling out and/or submission of insurance forms.*

Regardless of any insurance I may have, it is my responsibility to pay my bill. I hereby authorize my insurance company to pay Dr. Lyons directly for my care. I understand I am financially responsible for charges not covered by my insurance. Authorization to release my medical records for insurance purposes is granted by me.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_