EAR, NOSE, and THROAT
SPECIALISTS of WISCONSIN

Minor Patient Registration Form

Patient Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Mother or Legal Guardian Name_____

SSN _____ DOB_____

Address _____ City _____ State _____ Zip _____

Phone Home _____ Cell _____

E-mail _____

Father or Legal Guardian Name_____

SSN _____ DOB_____

Address _____ City _____ State _____ Zip _____

Phone Home _____ Cell _____

E-mail _____

Signature_____ Date_____

Relationship to Patient: _____

Please note that if, at any time, the minor patient will not be accompanied to an appointment by his/her parent or legal guardian, we require our Authorized Delegate for a Minor Form to be completed and on file. This form can be found on our website at www.entofwisconsin.com or we would be happy to provide you with a copy.