

Crawford & Fitch - Ear, Nose and Throat

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Today's Date: _____

Child's Name: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Sex: M F Home Phone Number: _____

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Number where parent or guardian can be reached: _____

Who is/are the child's Legal Guardians: _____

What relationship to patient: _____

Emergency Contact: _____ Phone Number: _____

What relationship to patient: _____

Primary Care Doctor:

Name: _____ Phone Number: _____

Whom may we thank for your referral? _____

I hereby authorize my child to have services rendered and treatment given when I can not accompany him/her. The following people are authorized, until revoked by my written instruction, to bring my child when I can not attend:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Insurance Authorization:

I verify that the above information is accurate and that these are the only insurances I have in effect at this time. I also understand that I am financially responsible for any charges for services rendered by Crawford and Fitch-Ear, Nose, and Throat.

Signature and Date: _____