Patient Registration

PEDIATRIC ASSOCIATES OF DURANGO

CHILDREN'S LEGAL NAME

1._____**DOB**_____ **Sex**_____

Race (Please circle one)

American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific
Black or African American
White
Hispanic
Other Race
Other Pacific Islander
Unreported/ Refused to Report

Ethnicity (Please circle one)

Hispanic or Latin
Not Hispanic or Latin
Refused to Report

2._____**DOB**_____ **Sex**_____

Race (Please circle one)

American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific
Black or African American
White
Hispanic
Other Race
Other Pacific Islander
Unreported/ Refused to Report

Ethnicity (Please circle one)

Hispanic or Latin
Not Hispanic or Latin
Refused to Report

3._____**DOB**_____ **Sex**_____

Race (Please circle one)

American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific
Black or African American
White
Hispanic
Other Race
Other Pacific Islander
Unreported/ Refused to Report

Ethnicity (Please circle one)

Hispanic or Latin
Not Hispanic or Latin
Refused to Report

4._____DOB_____ Sex_____

Race (Please circle one)

American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific
Black or African American
White
Hispanic
Other Race
Other Pacific Islander

Ethnicity (Please circle one)

Hispanic or Latin
Not Hispanic or Latin
Refused to Report

Patient Registration

Unreported/ Refused to Report

Name of Insurance: _____

Insurance Holder: _____

Insurance Holders Employer: _____Work#:_____

Father's Name:_____

Father's DOB_____Father's Social Security#:_____

Mother's Name:_____

Mother's DOB_____Mother's Social Security#:_____

Legal Guardian Name: _____

Legal Guardian Social Security#:_____Legal Guardian DOB: _____

Mailing Address: _____

City:_____State:_____ Zip:_____

Physical Address:_____

Home Telephone:_____

Dad Cell:_____Mom Cell:_____

Leave a message at: Home Cell Work

Preferred Language: _____

EMERGENCY CONTACT (other than self)

Name: _____ Relationship: _____Phone#:_____

Consent of release of information for prescription history:

Please sign here in order for Pediatric Associates of Durango to access information about medications your child/children have been prescribed in the past. This will help us take better care of your children.

Signature: _____

Preferred Pharmacy: _____

How did you hear about our clinic? (If another patient of our please list their name)

e.g. Phone book, newspaper ad, flyer, etc._____

Our practice now offers the opportunity to use the power of the web to track the most important aspects of your child's healthcare! The Patient Portal enables our patients to communicate with our staff easily, safely and securely via the Internet. Participating patients are able to access their personal information, request prescriptions, view test results and even request or cancel appointments. To sign up or learn more, please speak with anyone on our staff and we will be happy to assist you! Please enter your email address to receive general information about our clinic, our newsletter and to receive your Patient Portal User ID and password.

E-mail Address: _____

Authorization To Provide Necessary Care: I HEREBY AUTHORIZE PEDIATRIC ASSOCIATES OF DURANGO TO INSTITUTE ANY NECESSARY CARE, INCLUDING HOSPITALIZATION, IN MY ABSENCE FOR THE ABOVE CHILD.

Signature: _____Date:_____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC ASSOCIATES OF DURANGO FOR ANY BENEFITS AVAILABLE UNDER MY INSURANCE, AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES.

Signature:_____Date:_____

Patient Registration

- **If your account is sent to collections you will be charged an additional 27% of the total billed amount to cover collection costs.**

- **If your check is returned for insufficient funds there will be an additional $20 charge.**