PRE-REGISTRATION FORM

Please complete all information on BOTH pages

TODAY'S DATE: _____ **REASON FOR VISIT:** _____

PEDIATRIC ENDOCRINE ASSOCIATES, P.C.
8200 E. Belleview Avenue Suite 510E
Greenwood Village, CO 80111
Phone: 303-783-3883 FAX: 303-783-3800 www.denver pedendo.com

PATIENT INFORMATION:

Date and Time of Appointment: _____
Physician: Clifford A. Bloch, MD or Sunil Nayak, MD or Alicia G. Marks, DO
Has the patient been seen by Dr. Bloch, or Nayak or Marks before (Y/N)_____ Date:_____

Patient's full legal name: Last _____ First _____ Middle _____
Date of birth: Month _____ Day _____ Year _____ **Sex:** Male ☐ Female ☐
Primary Care Physician: _____ MD/DO Phone:( ) _____-_____
Street Address: _____ City: _____ St.: ____ Zip: _____
Referral source-Name: _____ Phone:( )_____-_____
Street Address: _____ City: _____ St.: ____ Zip: _____

GUARANTOR INFORMATION: (Person Responsible for the Bill)

Relationship to patient: Mother ☐ Father ☐ Legal Guardian ☐
If divorced who has legal custody: Mother ☐ Father ☐ Both ☐ Other_____
Name of Guarantor: _____ S.S.# _____
Guarantor's Employer Name:_____
Street Address:_____ City: _____ St.: _____ Zip: _____

NAME AND HOME ADDRESS:

Mother Name: _____
Home Phone: ( ) _____-_____
Work Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____
Street Address: _____
City: _____ St.: _____ Zip: _____
DOB: _____ Occupation: _____

Father Name: _____
Home Phone: ( ) _____-_____
Work Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____
Street Address: _____
City: _____ St.: _____ Zip:_____
DOB: _____ Occupation: _____

PRIMARY INSURANCE:

Insurance Co. Name: _____
Insurance Co. Phone: ( ) _____-_____
Street Address: _____
City: _____ St.: _____ Zip: _____
Insured's S.S.#: _____
CO-PAYMENT amount: $_____

Insured Name: _____
Insurance Group Name: _____
Policy #: _____
Group #: _____
Work ID#: _____

SECONDARY INSURANCE:

Insurance Co. Name: _____
Insurance Co. Phone: ( ) _____-_____
Street Address: _____
City: _____ St.: _____ Zip: _____
Insured's S.S.#: _____
CO-PAYMENT amount: $_____

Insured Name: _____
Insurance Group Name: _____
Policy #: _____
Group #: _____
Work ID#: _____

INSURANCE INFORMATION:

Please note: If your insurance plan requires a physician referral, **you are responsible for ensuring the referral is available at the time of the appointment.** Please present your insurance card at the time of the patient's appointment and be prepared to pay any necessary co-payment. Co-payments are due at the time of service (check, cash, Visa or MasterCard accepted)

OTHER PARENT OR GUARDIAN INFORMATION:

Name: _____ Relationship to patient: _____
Street Address: _____ Home Phone: ( ) _____-_____
City: _____ St.: _____ Zip: _____ Work Phone: ( ) _____-_____
Employer Name: _____ Cell Phone: ( ) _____-_____

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENT):

Name: _____ Relationship to patient: _____
Home Phone:( )_____-_____Work Phone:( )_____-_____ Cell Phone:( )_____-_____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of information from the above named patient's medical record that may be necessary to make reimbursement for any or all of the services rendered. I further understand that Pediatric Endocrine Associates, P.C., cannot be held responsible for the subsequent passage of information that might occur by the third parties themselves.

MISSED APPOINTMENTS:

I understand that I am responsible for being on time for my appointments. Failure to cancel an appointment 48 hours before the date will result in my being billed a $50.00 "missed appointment fee" and $100.00 for a missed stimulation test. **If I am more than 15 minutes late for an appointment, it will be regarded as a missed appointment.**

CONSENT FOR CARE:

On behalf of the above named patient, I do hereby apply for and voluntarily consent to outpatient care for my child ordered by Clifford A. Bloch, MD or Sunil Nayak, MD or Alicia G. Marks, DO or Mark Trottier, PA or Jean Bessey, MPH, RD.

PAYMENT INFORMATION:

Is this visit a self pay? Yes ____ No ____

I hereby authorize payment directly to directly to Pediatric Endocrine Associates, P. C.. Although every attempt will be made to bill insurance directly **I understand that I am financially responsible** to Pediatric Endocrine Associates, P.C. for any co-payments, co-insurance or charges not covered by insurance or for charges incurred by failure to obtain insurance authorization.

_____ _____
Signature of Insured Person or Authorized Rep. Date

_____
Printed Name of Insured Person or Authorized Rep.

Pediatric Endocrine Associates, p.c.
Infants • Children • Adolescents

Clifford A. Bloch, MD, FAAP
Pediatric Endocrinologist
Sunil Nayak, MD, FAAP
Pediatric Endocrinologist
Alicia G. Marks, DO
Pediatric Endocrinologist
Mark Trottier, PA-C
Jean Bessey, MPH, RD, CDE

Authorization to Leave Lab Results

I ,_____, parent of _____,

D.O.B._____, give Pediatric Endocrine Associates

the authorization to leave any lab results on the following

voicemails:

Home: (_____)_____

Work: (_____)_____

Cell: (_____)_____

_____

Signature Date

9/1/2013

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www.denverpedendo.com

Pediatric Endocrine Associates, P.C.
Infants • Children • Adolescents

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Pediatric Endocrinologist
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Release of Health Information ~ over 18 years of age

I _____ D.O.B_____

am 18 years or older. I give permission to Pediatric

Endocrine Associates to release my health information to the

following people at the following numbers:

_____ (____)_____
Name ~ Relationship Number

_____ (____)_____
Name ~ Relationship Number

_____ (____)_____
Name ~ Relationship Number

_____ _____
Signature Date

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