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 ____

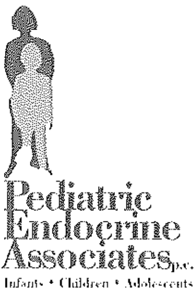
I hereby authorize payment directly to directly to Pediatric Endocrine Associates, P. C.. Although every attempt will be made to bill insurance directly **I understand that I am financially responsible** to Pediatric Endocrine Associates, P.C. for any co-payments, co-insurance or charges not covered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



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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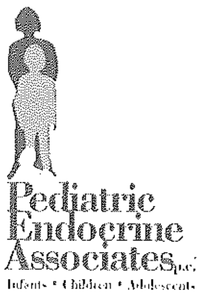
8200 E. Belleview Avenue • Suite 510E • Greenwood Village, Colorado 80111 • (303) 783-3883 • (303) 783-3800 fax
www.denverpedendo.com



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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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