Pediatric Endocrine Associates, P.C.

8200 E Belleview Ave, Suite 510-E
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PRE-REGISTRATION FORM

Please complete all information on **BOTH** pages.

Date: _____ **Reason for visit:** _____

Physician (please circle):
Clifford A. Bloch, MD Sunil Nayak, MD Alicia G. Marks, DO

PATIENT INFORMATION

Patient's Full Legal Name: Last_____ First_____ Middle_____
Patient's Preferred Name: _____
Date of Birth: Month _____ Day_____ Year _____ **Birth Sex:** Male___ Female____
Patient's Address: _____ City _____ St _____ Zip _____

Primary Care Physician: _____ Phone: _____
Street Address: _____ City_____ St_____ Zip_____
Referring Physician: _____ Phone: _____
Street Address: _____ City_____ St_____ Zip_____

PARENT INFORMATION

Parent/Guardian 1: _____
Home Phone:_____
Work Phone:_____
Cell Phone: _____
Street Address:_____
City_____ St _____ Zip_____
Relationship to Patient: _____
DOB:_____ Occupation:_____

Parent/Guardian 2: _____
Home Phone:_____
Work Phone:_____
Cell Phone: _____
Street Address:_____
City_____ St _____ Zip_____
Relationship to Patient: _____
DOB:_____ Occupation:_____

GUARANTOR INFORMATION

(Individual 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_____

INSURANCE INFORMATION

Please note: If your insurance plan requires a 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 (cash, check, Visa, MasterCard, Discover accepted).

PRIMARY INSURANCE

Insurance Co. Name:_____
Phone:_____
Street Address:_____
City_____ St_____ Zip_____
Specialty Visit Co-Pay: $_____

Policy Holder Name:_____
Policy Holder DOB:_____
Policy #:_____
Group #:_____

SECONDARY INSURANCE

Insurance Co. Name:_____
Phone:_____
Street Address:_____
City_____ St_____ Zip_____
Specialty Visit Co-Pay: $_____

Policy Holder Name:_____
Policy Holder DOB:_____
Policy #:_____
Group #:_____

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

Name:_____ **Relationship to Patient:**_____
Contact: 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 of 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 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 Bloch, MD; Sunil Nayak, MD; Alicia Marks, DO; Rebecca Somershoe, CNP; or Jean Bessey, MPH, RD.

PAYMENT INFORMATION

Is this visit a self pay? Yes_____ No _____

I hereby authorize payment 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. Please be aware that we will vault your credit card and bill the card directly after your appointment for the remaining balance not covered by insurance. See "Vault Policy" for further information.

_____ _____
Signature of Insured Person or Authorized Rep. Date

_____
Printed Name of Insured Person or Authorized Rep.