Allergy & Asthma Center

of Southern Oregon, PC

Edward M. Kerwin, MD Kevin W. Parks, MD Ryan B. Israelsen, MD

Jaleh K. Ostovar, FNP-C Jennifer K. Milligan, PA-C Kary A. Kelly FNP-C Tiffany R. Smith, PA-C

Appointments 1-541-858-1003 Fax (541) 857-4499

Pediatric Patient Registration Information:

Date:

Patient Name: _____ **DOB:** _____ **Age:** _____ **M / F**
First _____ M____ Last

Mailing Address: _____
Street City State Zip Code

Home Ph: _____ **Cell Ph:** _____ **Work Ph:**_____

E-Mail:_____ **How would you prefer to be contacted?** Home ❑ Cell ❑ Work ❑ Email ❑

Language:_____ **Patient's Ethnicity:** **Hispanic/Latino**_____ **Non-Hisp/Latino**_____ **Other**_____

Patient's Race: Caucasian___ African American___ Asian___ American Indian___ Hisp/Latino ___ Other___ Unknown___

Primary Care Doctor:_____ **Referring Doctor:**_____

PERSON RESPONSIBLE FOR PATIENT:

Mother's Name: _____ **DOB:** _____
First _____M_____ Last
Address (if different than patient): _____

Home Ph: _____ **Cell:** _____ **Work:** _____

Employer: _____ **Emp Ph:** **Emp Address:**

Father's Name: _____ **DOB:** _____
First _____M_____ Last

Address (if different than patient): _____

Home Ph: _____ **Cell:** _____ **Work:** _____

Employer: _____ **Emp Ph:** **Emp Address:**

INSURANCE COVERAGE:

Primary Insurance:_____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____
First _____ M_____ Last
ID Number: _____**Group Name:** _____**Relationship to Patient:** _____

Secondary Insurance: _____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____
First _____ M_____ Last
ID Number: _____**Group Name:** _____**Relationship to Patient:** _____

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the **patient or guardian's responsibility** to be aware of what is/is not covered by my insurance. The contract of insurance is between me and my insurance company, and I should clarify benefits with my insurer if any questions. I am ultimately responsible for payment of the services provided me. I hereby assign all medical and/or surgical benefits for initial and follow-up Allergy & Asthma Center (AAC) visits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to AAC. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Parent/Guardian:_____**Date:** _____