Allergy & Asthma Center
of Southern Oregon, PC
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Pediatric Patient Registration Information:

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

Okay to Contact via Email for: ❑Appointments ❑Medications ❑Medical Records ❑Other _____
By Indicating that you would like to receive emails you are giving consent to send Personal Health Information (PHI) via Email and understand the risk of unencrypted email.

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

Patient's Race: ❑Caucasian ❑African American ❑Asian ❑American Indian ❑Hisp/Latino ❑Other _____ ❑Unknown

Emergency Contact: _____ **Relation:** _____ **Emergency Phone:** _____ ❑Home ❑Cell

Ok to speak to ❑ Emergency Contact ❑ Other: _____ **❑Medications ❑ Labs ❑Appts ❑Billing**

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 Company Name: _____ **ID Number:**_____

Policy Holder:_____ **DOB:** _____ **Relationship to Patient:** _____
First M Last
Secondary Insurance Company Name: _____ **ID Number:**_____

Policy Holder:_____ **DOB:** _____ **Relationship to Patient:** _____
First M Last

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.

Printed Name of Parent/Guardian: _____

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