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

Primary Phone: _________________ ❑Home ❑Cell **Secondary Phone:** _________________ ❑Home ❑Cell **Email:** ______________________________

Okay to Contact via ❑**Text** ❑ **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.

INSURANCE COVERAGE:

Primary Insurance Company Name: ____

ID Number: ______________________________ **Group #** ______________________

Policy Holder: ❑**Mother** ❑**Father** ❑**Other:** ____
First M Last

(If Other) Policy Holder DOB: ________________ **Policy Holder Employer:** ____

Secondary Insurance Company Name: ____

ID Number: ______________________________ **Group #** ______________________

Policy Holder: ❑**Mother** ❑**Father** ❑**Other:** ____
First M Last

(If Other) Policy Holder DOB: ________________ **Policy Holder Employer:** ____

PERSON RESPONSIBLE FOR PATIENT:

Mother's Name: ____ **DOB:** __________________________
First M Last

Address (if different than patient) ____

Primary Ph: ______________________ ❑Home ❑Cell **Secondary Ph:** ____________________ **Email:** ______________________________

Father's Name: ____ **DOB:** __________________________
First M Last

Address (if different than patient): ____

Primary Ph: ______________________ ❑Home ❑Cell **Secondary Ph:** ____________________ **Email:** ______________________________

Additional Information

Patient's Language: ❑English ❑_________________ **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: ________________________________ **PCP Clinic Name:** ____________________________________

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:** ___________________