PARK VIEW PEDIATRICS

Please List All Children

Last Name	First Name	M.I.	Sex	Date of Birth
Last Name	First Name	M.I.	Sex	Date of Birth
Last Name	First Name	M.I.	Sex	Date of Birth
Last Name	First Name	M.I.	Sex	Date of Birth

Contact Information

Address: _____

Street Address Apartment/Unit City State Zip

_____

Mailing Address (If Different from Street Address) Apartment/Unit City State Zip

Phone: Home _____

Cell _____

Work _____ ext. _____

Email: _____

PVP **may** | **may not** leave messages on my answering machine. (Circle applicable answer)

PVP **may** | **may not** leave messages with other family members. (Circle applicable answer)

PVP may transmit electronically (via fax or e-fax) any health information to specialists, educational institutions, childcare/camp facilities and authorized caregivers. **X** initials

Government programs, such as Health First Colorado, have requested that we document the following information:

Please select one in each category.

Race:

_____ Asian
_____ Native Hawaiian/Other Pacific
_____ Black or African American
_____ White
_____ Hispanic
_____ Pacific Islander
_____ Decline to Report

Ethnicity:

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Decline to Report

Language:

_____ English
_____ Indian
_____ Spanish
_____ Russian
_____ Other
Please Specify: _____
_____Decline to answer

Parent/Guardian Information

Father's Name | Birth Date | Social Security Number | Email

Phone and Address (If different from above)

Mother's Name | Birth Date | Social Security Number | Email

Phone and Address (if different from above)

Emergency Contact (Other Than Parent)

Name | Relationship | Telephone Number

Authorized Caregivers

In my absence, I authorize Park View Pediatrics to provide any necessary treatment to my child. The following persons are authorized to bring my child in for medical care (i.e.: Grandparents, Stepparents, Nanny, Day Care Provider, etc.):

Name | Relationship | Telephone Number

Name | Relationship | Telephone Number

Insurance Information

******If no copy of insurance card is available, your account will be considered Self-Pay. ******

Primary Insurance Company | Subscriber Name/Date of Birth | Policy/Group Number

Secondary Insurance Company | Subscriber Name/Date of Birth | Policy/Group Number

_____ _____

Parent/Guardian Signature | Date