

TODAY'S DATE: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_

**PEDIATRIC ENDOCRINE ASSOCIATES, P.C.**  
8200 E. Belleview Avenue, Suite 510E  
Greenwood Village, CO 80111  
Phone: 303-783-3883 FAX: 303-783-3800 www.denverpedendo.com  
**PRE-REGISTRATION FORM**

Please complete all information on both pages.

**PATIENT INFORMATION:**

Date and Time of Appointment: \_\_\_\_\_

**Physician:** Clifford A. Bloch, M.D. or Sunil Nayak, M.D. or Aristides K. Maniatis, M.D.

Has patient been seen by Dr. Bloch or Nayak or Maniatis before? (y/n) \_\_\_\_\_ Date \_\_\_\_\_

**Patient's full legal name:** Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**Date of birth:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Sex:** Male \_\_\_\_\_ Female \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ MD/DO Phone: ( ) \_\_\_\_\_

**Physician Address:** \_\_\_\_\_  
\_\_\_\_\_

**Referral Source:** Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

**GUARANTOR INFORMATION:** (Person 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.# \_\_\_\_\_

**Phone: Mother: Home:** ( ) \_\_\_\_\_ **Father: Home:** ( ) \_\_\_\_\_

**Office:** ( ) \_\_\_\_\_ **Office:** ( ) \_\_\_\_\_

**Cell:** ( ) \_\_\_\_\_ **Cell:** ( ) \_\_\_\_\_

**Name and Home Address**

**Mother [Name]:** \_\_\_\_\_ **Father [Name]:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Occupation: Mother:** \_\_\_\_\_ **Father:** \_\_\_\_\_

Guarantor=s Employer Name: \_\_\_\_\_

Guarantor=s Work Address: \_\_\_\_\_

**PAYMENT INFORMATION:**

Is this visit a self pay? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please discuss payment with the practice.

**PRIMARY INSURANCE:**

Insured Name: \_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone:( ) \_\_\_\_\_ Insurance Group Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Work ID# \_\_\_\_\_

If this is an HMO, amount of CO-PAYMENT: \$ \_\_\_\_\_

**SECONDARY INSURANCE:**

Insured Name: \_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Phone: ( ) \_\_\_\_\_ Insurance Group Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Work ID# \_\_\_\_\_

**Please note:** If your insurance plan requires a physician 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 patient's appointment and be prepared to pay any necessary co-payment. Co-payments are due at the time of service [check or cash]. Please note that we do not take credit cards.

**OTHER PARENT OR GUARDIAN INFORMATION:**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Address of Employment: \_\_\_\_\_  
\_\_\_\_\_

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

Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**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 or 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 hrs before the date will result in my being billed a \$50- missed appointment fee. [\$100- for a missed stimulation test] **If I am 15 or more minutes late for an appointment for whatever reason, 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 A. Bloch, M.D. or Sunil Nayak, M.D. or Aristides K. Maniatis, M.D. or Mako Sather, PNP.

**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, charges not covered by insurance or for charges incurred by failure to obtain insurance authorization.

Date: \_\_\_\_\_  
Signature of insured person or authorized Rep.