**DESERT PEDIATRICS**

**2150 S. Eastern Avenue**
**Las Vegas, Nevada 89104**
**Phone (702) 641-2150**
**Fax (702) 641-8667**

**7180 Cascade Valley Court #180**
**Las Vegas, Nevada 89128**
**Phone (702) 641-2150**
**Fax (702) 228-1043**

PLEASE PRINT AND FILL OUT COMPLETELY
PATIENT / PARENT INFORMATION

**EMAIL ADDRESS:**_____

**CHILD'S NAME:**
(LAST)_____(FIRST)_____(MI)_____
HAS THIS CHILD BEEN KNOWN BY ANY OTHER NAME:_____
SEX:_____BIRTHDATE:_____ PREFERRED LANGUAGE:_____
RACE:_____ETHNICITY: ( )HISPANIC ( ) NON-HISPANIC ( )OTHER_____
HOME PHONE NUMBER: ( )-_____ALTERNATE #: ( )-_____
STREET ADDRESS:_____APT #:_____
CITY:_____STATE:_____ZIP:_____

**MOTHER'S NAME:**
(LAST)_____(FIRST)_____(MI)_____
HOME PHONE NUMBER: ( )-_____ALTERNATE #: ( )-_____
STREET ADDRESS:_____APT #:_____
CITY:_____STATE:_____ZIP:_____
SOCIAL SECURITY #:_____BIRTHDATE:_____
EMPLOYER:_____EMPLOYER'S PHONE:_____
OCCUPATION:_____

**FATHER'S NAME:**
(LAST)_____(FIRST)_____(MI)_____
HOME PHONE NUMBER: ( )-_____ALTERNATE #: ( )-_____
STREET ADDRESS:_____APT#:_____
CITY:_____STATE:_____ZIP:_____
SOCIAL SECURITY #:_____BIRTHDATE:_____
EMPLOYER:_____EMPLOYER'S PHONE:_____
OCCUPATION:_____

**NAME AND PHONE # OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF AN EMERGENCY:** NAME:_____
PHONE #: ( )-_____RELATIONSHIP:_____

**INSURANCE AUTHORIZATION FOR BENEFIT ASSIGNMENT AND INFORMATION RELEASE**

I AUTHORIZE DESERT PEDIATRICS, ALL MEDICAL PROVIDERS LISTED ABOVE, TO PROVIDE MEDICAL CARE FOR MY CHILD AS NECESSARY. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE PLAN, I ALSO AUTHORIZE DESERT PEDIATRICS TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING THE HEALTH CARE PROVIDED. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTRATING CLAIMS FOR BENEFITS. INFORMATION REQUESTED FOR ANY OTHER PURPOSE WILL REQUIRE MY SIGNATURE FOR RELEASE.

**DATE:**_____**SIGNED:**_____
PARENT/GUARDIAN/RESPONSIBLE PARTY