

Pediatric Associates of Avon

Patient Registration

Date: _____

Physician: Dr. Cosgrove • Dr. Gill • Dr. Patel • Dr. Shmalo

Patient Information

Name: _____

Date of Birth: _____ Male ___ Female ___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___ Declined to specify ___

Race: American Indian or Alaska Native ___ Asian ___ White ___ Declined to specify ___

Black/African American ___ Native Hawaiian or Other Pacific Islander ___

SSN: _____ - _____ - _____

Address: _____

City: _____

State: _____ Zip _____

Home Phone: _____

Mom Cell: _____

Dad Cell: _____

Email Address: _____

Pharmacy: _____

Mail in Pharmacy: _____

Referred by: _____

Responsible Party (Person who will receive statements)

Name: _____

Address: _____

City: _____

State: _____ Zip _____

Parent Information

Mother's Name: _____

Address: _____

(if different from patient)

DOB: _____ SSN: _____ - _____ - _____

Employer: _____

Employer Phone: _____

Father's Name: _____

Address: _____

(if different from patient)

DOB: _____ SSN: _____ - _____ - _____

Employer: _____

Employer Phone: _____

Custodial Parent (if divorced): _____