Pediatric Associates of Avon

Patient Registration

Date: ___________________________

Physician: Dr. Cosgrove • Dr. Gill • Dr. Lopez • 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 ___

Back/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): _____________________________