THE PEDIATRIC CENTER
4745 Arapahoe Ave., Suite 310
Boulder, CO 80303
(303) 442-2913
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Naomi Feiman, M.D
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PATIENT REGISTRATION

(Please complete all blanks)

Family Last Name: ____ Date: ___________________

Names of Children

____ Birthdate ___________________ Sex M F

____ Birthdate ___________________ Sex M F

____ Birthdate ___________________ Sex M F

____ Birthdate ___________________ Sex M F

Is anyone in the family American Indian or Alaskan Native: Y N

Parent Responsible for Payment:

Name ____ Relationship ______________

Address ____ Home Phone _________________

City ____________________________________ State ___________ Zip ________________

Family Email address ____
(this will be kept secure and will not be shared with any other offices/companies)

Father ________________________________ Employer __________________________________

Birthdate ___________ Work Phone ____________________ Cell Phone ___________________

Mother _______________________________ Employer __________________________________

Birthdate ___________ Work Phone ____________________ Cell Phone __________________

Medical Insurance Information None ☐

Name of Company ____________________________ Policy Holder _________________________

ID#:____ Group # _____________________________

I authorize payment of medical benefits to my physician for professional services rendered.
I authorize the release of any medical information to my insurance company.

Signature _____________________________________

Person to contact in case of an emergency other than parent

Name ____ Phone ___________________

If I am unavailable, I request The Pediatric Center, or any physician they may delegate, to give any and all medical or surgical care to the above named children. This includes my permission for the children to be admitted to a hospital and for the performance of surgery and anesthesia as deemed advisable by the above named physicians or their delegates.

Signed ____