Children's Lung Specialists, Ltd.
3820 Meadows Lane, Las Vegas, NV 89107-3113

# PATIENT REGISTRATION FORM

**Patient Information:**

Last Name_____ First _____ Middle_____

Male or Female DOB_____/_____/_____ Social Security # _____

Language Spoken _____ Ethnicity _____

Address_____

City/State/Zip_____Home Phone #_____

***If applicable for patient:***

Employer_____Occupation_____

Address_____Work Phone #_____

**If patient is a child, please complete the following:**

Mother's Name_____ DOB_____/_____/_____ SS#_____

Home Phone #_____Work Phone #_____

Occupation_____Employer_____

Father's Name_____DOB_____SS#_____

Home Phone #_____Work Phone #_____

Occupation_____Employer_____

**Primary Insured Information**

Primary Guarantor Name_____Relationship_____

(Skip to Insurance Information if same as above)

Male or Female DOB____/____/____ SS#_____ Home Phone #_____

Occupation_____Employer_____

Work Address _____Work Phone# _____

Insurance Company Name_____

Policy Effective Date_____/_____/_____ Policy Termination Date _____/_____/_____

ID# _____ Group# _____

## Secondary Insured Information

Secondary Guarantor Name_____Relationship_____

(Skip to Insurance Information if same as above)

Male or Female DOB____/____/____ SS#_____ Home Phone #_____

Occupation_____Employer_____

Work Address _____Work Phone# _____

Insurance Company Name_____

Policy Effective Date_____/_____/_____ Policy Termination Date _____/_____/_____

ID# _____ Group# _____

*Primary Care Physician or Specialist _____

*Referring Physician or Individual _____

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Children's Lung Specialists, Ltd., and I understand that I am financially responsible for charges for medical services rendered to the above named patient, regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

Patient or Guarantor's Signature _____ Date_____

*If you would like to receive billing statements via e-mail, please leave your e-mail address below:

E-mail _____