Thida Maw, M.D. Pediatrics
Patient Registration

Children's information

Last Name	First	Middle Initial	Date of Birth	Male/Female

Parent/ Guarantor Information

Father's Name:_____ DOB:_____ e-Mail:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

_____
Address **City, State, Zip code**

Mother's Name:_____ DOB:_____ e-Mail:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

_____
Address (*only if different*) **City, State, Zip code**

Ethnicity (check one)
- □ Hispanic
- □ Non- Hispanic
- □ Refused to report

Primary Race (check one)
- □ White
- □ Hispanic
- □ African American/ Black
- □ Asian
- □ Native American
- □ Native Hawaiian
- □ Other Pacific Islander
- □ Other Race
- □ Unreported/ Refused

Preferred language (check one): □ English □ Spanish □ other:_____
Interpreter needed? □ Yes □ No

Emergency contact:_____ Relationship:_____
Name **Telephone Number**

Do we have permission to contact this person regarding matters concerning your child's care? □ Yes □ No

Preferred Pharmacy #1
Name:_____ Address:_____ Phone Number:_____
Mail order? □ Yes □ No

Preferred Pharmacy #2
Name:_____ Address:_____ Phone Number:_____
Mail order? □ Yes □ No

Electronic Prescriptions*: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*
Immunizations*: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your provider to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*
Assignment of insurance benefits: *I hereby authorize direct payment of benefits to Thida Maw, M.D. for services rendered by her or under her supervision. I understand that I am responsible for any balance not covered by my insurance.*

Parent Signature:_____ Date:_____

A photocopy of these assignments shall be valid as the original. Copayment/ payment required at the time of visit.