



INTERNATIONAL ADOPTION MEDICAL SUPPORT SERVICES

ALLA GORDINA, MD, FAAP

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PROSPECTIVE ADOPTIVE PARENT REGISTRATION

(Please complete the entire form)

	Mother	Father
Name Last		
Name First		
DOB		
Occupation		
SS#		
Home address and telephone		
Cell phone		
Work phone		
Fax		
E-mail		

Who recommended Global Pediatrics to you? _____

ADOPTION AGENCY INFORMATION or facilitator:

Name _____

Address _____

Telephone (____) _____ Fax (____) _____

E-mail _____ Contact Person _____

Anticipated date of travel _____

Region (if known) _____

Do you have any children presently, any previous experience with international adoptions, domestic adoptions/foster care, etc.



Information about a child/children you are planning to adopt (age, sex, special needs, etc) or any issues you want to discuss with us. You can use additional pages if needed.

Date _____ Signature _____.

BILLING INFORMATION

No services will be provided without payment.

If paying by the check – make sure to make it payable to **Dr. Gordina**.

If paying by credit card – please provide information and copies of your credit card and driver license (both sides)

Name of the responsible party _____

Billing address: _____

Telephone _____ *Fax* _____

<i>CC number</i>																			
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<i>MC</i>	<input type="checkbox"/>	<i>Visa</i>	<input type="checkbox"/>	<i>Exp. date</i>			<i>Security code*</i>			
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*Security code is a 3-digit code printed on the back of your card next to the CC number

Authorized charges

- () \$500 initial referral,
- () \$250 each additional review
- () additional \$250 for emergency review (within 48 hours from initial contact with the office or when doctor is out of the office)

TOTAL \$ _____

Signature of the responsible party: _____