Welcome

Patient Information

Date: _____

Name: _____

DOB: _____ Age: _____ Sex: F M

Address: _____

City: _____

State: _____ Zip: _____

Patient's Soc Sec #: _____

Phone: _____

Email: _____

Parents Information

Parents are:

Single □ Married □ Separated □ Divorced □ Widowed □

Father's Information

Name: _____

DOB: _____

Soc Sec #: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Cell Phone: _____

Work Phone: _____

Employer/ Occupation: _____

Mother's Information

Name: _____

DOB: _____

Soc Sec #: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Cell Phone: _____

Work Phone: _____

Employer/ Occupation: _____

Pharmacy

Pharmacy Name: _____

Address: _____

City: _____ State: _____

Phone: _____

Insurance

Guarantor: _____

Relationship to patient: _____

DOB: _____ SS#: _____

Insurance: _____

ID#: _____ Group#: _____

Assignment and Release

I, the undersigned hereby authorize Santa Clarita Pediatrics to furnish information to insurance carriers concerning this illness/ accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that *I am financially responsible for all charges whether or not covered by insurance*. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Responsible Party Signature

_____ _____

Relationship Date

Emergency Contact

(Other than the parents)

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Patient Referred By

□ Doctor: _____

□ Friend: _____

□ Yellow Pages □ Magazine of Santa Clarita

□ Santa Clarita Newcomer/Community Resource Guide

□ Yelp □ Google □ Other _____