PATIENT INFORMATION FORM

HOME ADDRESS: ____

HOME PHONE: ____

CITY / STATE / ZIP: ____

MOTHER OR GUARDIAN: SS #: ______________________

MOTHER EMPLOYER: __________________________________

MOTHER'S WORK PHONE: ________________________

MOTHER'S CELL PHONE: _________________________

MOTHER'S DOB: ____________________________

FATHER OR GUARDIAN: SS #: _______________________

FATHER EMPLOYER: ___________________________

FATHER'S WORK PHONE: _________________________

FATHER'S CELL PHONE: __________________________

FATHER'S DOB: _____________________________

REFERRED BY: ______________________________________

NAME OF FRIEND/RELATIVE NOT LIVING WITH YOU: PHONE:

____

PRIMARY INSURANCE CO: __________________________________

PRIMARY INSUREDS NAME: _________________________________

INSURANCE ADDRESS: ____________________________________

CITY / STATE / ZIP: _____________________________________

GROUP#: _______________________________

INSURANCE ID #: _____________________________

INSURED'S NAME: _____________________________

OTHER INSURANCE INFO AND ID #: ____________________________________

Do we have permission to add your email address to our Pediatrics in Paradise newsletter database so that you may receive our monthly newsletters? (We will not share your email for any other purpose). No / Yes and then enter email address below:

EMAIL: ____

Chula Vista (619) 482-1700
National City (619) 475-4575
www.PediatricsinParadise.com

PATIENT INFORMATION FORM

The undersigned agrees that all services are rendered on a paid basis only. Our policy is to collect for services at the time they are rendered. If collection becomes necessary, the undersigned shall pay all reasonable costs.

We will bill insurance for those companies that we have a contractual obligation to do so. The undersigned agrees to authorize insurance benefits to be paid directly to the physician. The undersigned is responsible for all non-covered services. The undersigned authorizes the physician to provide any information required to process claims for benefits.

Parents agree to have chart notes copied and forwarded when requested by specialist or school.

____________________________________ ____________________
MOTHER OR GUARDIAN SIGNATURE DATE

____
MOTHER OR GUARDIAN (PRINT NAME)

____________________________________ ____________________
FATHER OR GUARDIAN SIGNATURE DATE

____
FATHER OR GUARDIAN (PRINT NAME)