Bakersfield Pediatrics

PATIENT INFORMATION

Childs #1 Name:_____D.O.B____/____/____
Last First Middle
Sex: Male or Female Social Security# ____/___/____ Relationship to Guarantor: _____
(Circle One)

Childs #2 Name:_____D.O.B____/____/____
Last First Middle
Sex: Male or Female Social Security# ____/___/____ Relationship to Guarantor: _____
(Circle One)

HAVE ANY OF YOUR CHILDREN RECEIVED TREATMENT HERE IN OUR OFFICE? YES NO

MOTHER/STEPMOTHER/GUARDIAN: (Please circle one)
Name_____D.O.B._____/_____/_____
Address_____ City, St, Zip_____
Mailing Address: _____
Phone No. ( ) _____ Cell #_____ SS#_____-_____-_____
Employer_____ WK#_____ Occupation_____
Drivers License#:_____

FATHER/STEPFATHER/GUARDIAN: (Please circle one)
Name_____D.O.B._____/_____/_____
Address_____ City, St, Zip_____
Mailing Address: _____
Phone No. ( ) _____Cell#_____ SS#_____-_____-_____
Employer_____ WK#_____ Occupation_____
Drivers License#:_____

Emergency Contact: *(non-parent)*
Name: _____Phone#:_____
Relation: _____

Primary Insurance
Insurance Company_____
Subscriber Name_____
Date of Birth_____/_____/_____
Relationship to Patient: _____

Secondary Insurance
Insurance Company_____
Subscriber Name_____
Date of Birth_____/_____/_____
Relationship to Patient: _____

I hereby authorize any physician, practitioner, insurance company, or third party to disclose to each other needed protected information that is relevant to my child's health to carry out medical treatment, health care operations, payment, or for any other purpose that is permitted or required by law. A photocopy of this authorization shall be the same as the original. I hereby certify the statements hereon and those attached are true and correct to the best of my knowledge. I understand it is fraudulent to fill out this form with information I know to be false or to omit important facts.

Signature_____ Date _____/_____/_____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN PATIENT:
I hereby authorize direct payment of surgical/medical benefits for services rendered by Bakersfield Pediatrics and all other office personnel. I understand that I am financially responsible for any services rendered that may not be covered by my insurance.

Signature_____ Date_____/_____/_____