Valencia Pediatric ASSOCIATES

PATIENT REGISTRATION (0-17 YEARS)

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt#

_____
City State Zip

Date of Birth (mm/dd/yyyy): _____ Social Security No:_____ Sex (circle): ○M ◉F

Phone number to send remind text messages to: (_____)_____

E-mail Address for Patient Portal: _____

Parent/Legal Guardian:_____

Relationship to Patient: ○Mother ○Father ◉Other:_____

Date of Birth (mm/dd/yyyy): _____

Social Security Number: _____

Address (if different): _____

_____

Cell Phone: (_____)_____ OK to leave message? ○Y ◉N

Home Ph: (_____)_____ OK to leave message? ○Y ◉N

Best Contact Number (circle): ○Cell ◉Home

Parent/Legal Guardian:_____

Relationship to Patient: ○Mother ○Father ◉Other:_____

Date of Birth (mm/dd/yyyy): _____

Social Security Number: _____

Address (if different): _____

_____

Cell Phone: (_____)_____ OK to leave message? ○Y ◉N

Home Ph: (_____)_____ OK to leave message? ○Y ◉N

Best Contact Number (circle): ○Cell ◉Home

IN CASE OF EMERGENCY: (OTHER THAN THE PARENT/GUARDIAN)

Name of Emergency Contact Person: _____ Relationship to Patient: _____

Cell Phone: (____)_____ Alternate Phone : (____)_____

INSURANCE INFORMATION:

PRIMARY INS. NAME: _____

Policy Holder: _____

Patient's Relationship to Insured: _____

Policy ID#: _____

Group#: _____

SECONDARY INS. NAME: _____

Policy Holder: _____

Patient's Relationship to Insured: _____

Policy ID#: _____

Group#:_____

I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance to be paid directly to Valencia Pediatric Associates or its assignees. This acceptable and assignment will be in force for all future services by practitioners from this office. I agree that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Signature (Patient or Parent if minor) Relationship to Above Patient Date Rev: 2/24/2017