* office use only
DOC: _____
Date: _____
Time: _____
Today's date: _____

# El Camino Pediatrics

Mother or Guardian _____

SS# _____ D.O.B. _____

Father or Guardian _____

SS# _____ D.O.B. _____

ADDRESS _____
street

_____
city state zip

PHONE _____
home cell

_____
Father work Mother work

Mother's Employer _____

Father's Employer _____

Who referred you? _____

Primary Insurance Co. _____

Primary Insured's name _____

Insurance ID # _____

Policy or Group # _____

Effective date: _____

Other Insurance: _____

| LIST **ALL** CHILDREN'S NAMES | SEX | BIRTH DATE | * OFFICE USE ONLY |
|---|---|---|---|
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| | | | |

Friend or relative not living with you ( for emergency use only)

NAME PHONE

Company Address _____
Street

_____
city state zip

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 a specialist or school.

_____ _____
Mother or Guardian date Father or Guardian date