



El Camino Pediatrics

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

HOME ADDRESS: _____ HOME PHONE: _____

CITY: _____ ST: _____ ZIP: _____

MOTHER OR PARENT 1 (P1): _____ SS #: _____

MOTHER OR P1 EMPLOYER: _____ MOTHER OR P1 WORK PHONE: _____

MOTHER OR P1 CELL PHONE: _____ MOTHER OR P1 DOB: _____

FATHER OR PARENT 2 (P2): _____ SS #: _____

FATHER OR P2 EMPLOYER: _____ FATHER OR P2 WORK PHONE: _____

FATHER OR P2 CELL PHONE: _____ FATHER OR P2 DOB: _____

REFERRED BY: _____

NAME OF FRIEND/RELATIVE NOT LIVING WITH YOU: _____ PHONE: _____
(emergency use only)

RELATIONSHIP: _____

PRIMARY INSURANCE CO: _____

PRIMARY INSURED'S NAME: _____

INSURANCE ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

GROUP#: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____

INSURED'S NAME: _____

OTHER INSURANCE INFO AND ID #: _____

ALL CHILDREN'S NAMES	S E X	DOB	OFFICE USE ONLY

Do we have permission to add your email address to our El Camino Pediatrics 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: _____

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 Parent 1 Date

Father or Parent 2 Date