PACIFIC PEDIATRICS MEDICAL GROUP, INC.
Patient Registration Form

PATIENT NAME (LAST, FIRST MIDDLE)		DATE OF BIRTH	SEX	TODAY'S DATE (MM/DD/YYYY)
ADDRESS	CITY	STATE ZIP		HOME PHONE# ( )

ETHNICITY (PLEASE CIRCLE ONE)	RACE (PLEASE CIRCLE ONE)	PRIMARY LANGUAGE:
Declined / Hispanic / Non-Hispanic	American Indian or Alaska Native / Asian / Black or African American / Declined /	
Not Reported / Unknown	Native Hawaiian or Pacific Islander / Not Reported / Other / Unknown / White	

PARENT 1 (LAST, FIRST MIDDLE)	DATE OF BIRTH	SEX	SS#	LIVING WITH PATIENT?
				Yes / No
RELATIONSHIP	CELL PHONE # ( )		E-MAIL ADDRESS	
NAME AND ADDRESS OF EMPLOYER	WORK PHONE# ( )		OCCUPATION	

PARENT 2 (LAST, FIRST MIDDLE)	DATE OF BIRTH	SEX	SS#	LIVING WITH PATIENT?
				Yes / No
RELATIONSHIP	CELL PHONE # ( )		E-MAIL ADDRESS	
NAME AND ADDRESS OF EMPLOYER	WORK PHONE# ( )		OCCUPATION	

IN CASE OF EMERGENCY CONTACT	NAME (LAST, FIRST MIDDLE)	PHONE#	RELATIONSHIP
		( )	

WHOM MAY WE THANK FOR REFERRING YOU TO US?	WHO IS YOUR PRIMARY CARE PHYSICIAN? (PLEASE CIRCLE ONE)
	Daniel Kelly, Barry Rostek, Yasuko Fukuda, Allison Goodyear, Jean Lee

WHAT IS THE NAME AND ADDRESS OF YOUR PREFERRED PHARMACY?

PATIENT'S BROTHERS & SISTERS

NAME (LAST, FIRST MIDDLE)	DATE OF BIRTH (MM/DD/YYYY)

I authorize the release of information necessary to process claims, and authorize payment of medical benefits directly to the physician for those you bill.
I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered 30 days after date of service. I have read all the information contained in this document. I certify that all the information that I have provided is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

PARENT 1

SIGNATURE _____

NAME (Print) _____

PARENT 2

SIGNATURE _____

NAME (Print) _____