PACIFIC PEDIATRICS MEDICAL GROUP, INC.

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?

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. 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) _____

Last Update: 9/28/16