GLENDALE PEDIATRICS

(Birth through 17 years of age)

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

*List **ALL** of your children below :* DATE : ___/___/_____

CHILDREN'S FULL LEGAL NAME:

Patient of Glendale Peds

Office use 2015

1. _____ M F ____/____/____ Y / N
   Last First Middle Circle one DOB: mm/dd/yyyy
2. _____ M F ____/____/____ Y / N
   Last First Middle Circle one DOB: mm/dd/yyyy
3. _____ M F ____/____/____ Y / N
   Last First Middle Circle one DOB: mm/dd/yyyy
4. _____ M F ____/____/____ Y / N
   Last First Middle Circle one DOB: mm/dd/yyyy

With whom do the children above reside? ☐ Both Parents ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _____

Patient(s) Primary Address _____

Patient(s) Secondary Address _____

Guardian's Name Street Address Apt City State ZIP Code

PARENT OR LEGAL GUARDIAN CONTACT INFORMATION (*Please list contact numbers in order of preference*)

_____ (____)_____ ☐ Home ☐ Cell ☐ Work - OK to leave message? Y N
Name Relationship Phone Number

_____ (____)_____ ☐ Home ☐ Cell ☐ Work - OK to leave message? Y N
Name Relationship Phone Number

_____ (____)_____ ☐ Home ☐ Cell ☐ Work - OK to leave message? Y N
Name Relationship Phone Number

Child's / Children's parents are: ☐ Married ☐ Separated * ☐ Divorced * ☐ Other *(please specify)_____ * See additional form

PARENT or LEGAL GUARDIAN INFORMATION:

Relationship to Patient (check one) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other _____ (Please specify)

_____ Date of Birth ___/___/___ Last 4 # of SSN _____ Drivers Lic # _____
Last name First Name mm/dd/yyyy

Employer : _____ Occupation : _____
Name City State

Relationship to Patient (check one) ☐ Mother ☐ Father ☐ Grandparent ☐ Stepparent ☐ Other _____ (Please specify)

_____ Date of Birth ___/___/___ Last 4 # of SSN _____ Drivers Lic # _____
Last name First Name mm/dd/yyyy

Employer : _____ Occupation : _____
Name City State

IN CASE OF EMERGENCY, CONTACT: _____ Phone : (____) _____
(Person not living in the same house)

How were you referred to our office : _____ Prior Physician: _____

Name of **Primary** Insurance :_____
Policy subscriber's name : _____
DOB___/____/____ Subscriber ID #:_____ Group #:_____

Name of **Secondary** Insurance :_____
Policy subscriber's name : _____
DOB___/____/____ Subscriber ID #:_____ Group #:_____

I hereby assign my insurance benefits to be paid directly to Glendale Pediatrics, A Professional Corporation. I am responsible for informing Glendale Pediatrics of any specific labs, x-rays and other ancillary services that my insurance company is contracted with. I am financially responsible for non-covered services, co pays and deductibles. I authorize Glendale Pediatrics, A Professional Corporation, to release to my insurance carriers any information required to process my child's (children's) claims.

SIGNATURE: _____ DATE: _____