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WHITTIER PEDIATRIC GROUP

8522 Painter Ave.
Whittier, CA 90602

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PATIENT INFORMATION

LAST NAME: ____________ FIRST NAME: ____________ MIDDLE INITIAL: ______
DATE OF BIRTH/(DOB): ____________ SEX: ☐ MALE ☐ FEMALE
ADDRESS: ____________ CITY, ZIP CODE: ____________
PATIENT LIVES WITH: ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER ____________
PREFFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ MANDARIN ☐ OTHER ____________
ETHNICITY: ☐ HISPANIC ☐ NON HISPANIC ☐ ASIAN ☐ OTHER ____________
*APA requests information on Ethnicity to meet Federal Meaningful use criteria.

PARENT INFORMATION

MOTHER/GUARDIAN LAST NAME: ____________ FIRST NAME: ____________
ADDRESS: ____________ CITY, ZIP CODE: ____________
(If different from patient)
PHONE NUMBER: ☐ CELL: ____________ ☐ HOME: ____________ ☐ WORK: ____________
(Please check preferred contact number)
EMAIL: ____________
DATE OF BIRTH/(DOB): ____________ SOCIAL SECURITY #: ____________ EMPLOYER: ____________
FATHER/GUARDIAN LAST NAME: ____________ FIRST NAME: ____________
ADDRESS: ____________ CITY, ZIP CODE: ____________
(If different from patient)
PHONE NUMBER: ☐ CELL: ____________ ☐ HOME: ____________ ☐ WORK: ____________
(Please check preferred contact number)
EMAIL: ____________
DATE OF BIRTH/(DOB): ____________ SOCIAL SECURITY #: ____________ EMPLOYER: ____________

ADDITIONAL CHILDREN IN THE FAMILY INFORMATION (IF MORE SPACE IS NEEDED PLEASE LIST CHILDREN ON BACK.)

NAME/DOB: ____________ NAME/DOB: ____________
NAME/DOB: ____________ NAME/DOB: ____________
NAME/DOB: ____________ NAME/DOB: ____________

Please list below additional persons who may bring your child/ren to appointments, or who we are authorized to communicate with regarding visits, medical information, etc. Example Step-Parent, Grandparent, Aunt, Care Giver, etc.

NAME: ____________ RELATIONSHIP: ____________ PHONE#: ____________
NAME: ____________ RELATIONSHIP: ____________ PHONE#: ____________
NAME: ____________ RELATIONSHIP: ____________ PHONE#: ____________

EMERGENCY INFORMATION (IN CASE OF EMERGENCY WHOM TO CONTACT OTHER THAN PARENTS)

NAME: ____________ RELATIONSHIP TO PATIENT: ____________
ADDRESS: ____________ CITY, ZIP CODE: ____________
PHONE #: HOME: ____________ CELL: ____________

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD AT EACH VISIT.)

PRIMARY: ____________ ID#: ____________ SUBSCRIBER: ____________ DOB: ____________
SECONDARY: ____________ ID#: ____________ SUBSCRIBER: ____________ DOB: ____________

REFERRED BY: ____________

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS/PRIVACY POLICY

1. I/We authorize the release of any medical information necessary to process this claim. I/ We permit a copy of this authorization to be used in the place of the original. I/We hereby authorize payment of medical benefits to be paid to **Whittier Pediatric Group and all their associates.** I/We understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations. I understand that my **Insurance Card must be presented at EVERY VISIT.**
2. I understand that I am financially responsible for all professional charges that my child may incur. Payment for these services rendered is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of services or promptly when billed. Delinquent accounts will be sent a letter of intent to be sent to collections. I understand I will be responsible for any collection/attorney fees incurred.
3. Acknowledgement of Receipt of HIPPA NOTICE OF PRIVACY PRACTICES: I/We have received, or have been given the opportunity to receive, a copy of **HIPPA NOTICE OF PRIVACY PRACTICES FOR WHITTIER PEDIATRIC GROUP.**

____________ SIGNATURE OF PARENT/LEGAL GUARDIAN

____________ DATE