

PATIENT INFORMATION
PLEASE PRINT CLEARLY

CHILD'S NAME _____ **M or F** **BIRTHDATE:** _____
Last First MI

Name used during newborn hospitalization if different than above:

FATHER'S INFORMATION

MOTHER'S INFORMATION

Name: _____

Name: _____

Address: _____
(Street)

Address: _____
(Street)

(City)

(City)

(State) (Zip Code)

(State) (Zip Code)

Phone Numbers: Home() _____

Phone Numbers: Home() _____

Work () _____

Work () _____

Cell () _____

Cell () _____

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Social Security #: _____

Social Security #: _____

NAME OF OTHER CHILDREN: _____ M or F BIRTH DATE _____
SEEN IN THIS OFFICE

_____ M or F BIRTH DATE _____

_____ M or F BIRTH DATE _____

INSURANCE INFORMATION

Policy Name ID#

Subscriber Name Group#

**EMERGENCY CONTACT
OTHER THAN PARENT**

Name Phone#

Address Relation to Patient

I UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING MY INSURANCE CARD, COMPLETE INSURANCE INFORMATION AND COPAYMENT AT THE TIME OF MY CHILD'S VISIT. AS APPROPRIATE, I MAY BE BILLED FOR ANY INSURANCE DEDUCTIBLE OR SERVICES THAT ARE NOT COVERED BENEFITS.

I UNDERSTAND THAT A MISSED APPOINTMENT (FOR A WELL CHILD APPT) WITHOUT 24 HR NOTICE OF CANCELLATION MAY RESULT IN A \$25 CHARGE.

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN.

SIGNED: _____ DATE _____

I HAVE RECEIVED A COPY OF FOSTER CITY PEDIATRICS' PRIVACY PRACTICES

SIGNED: _____ DATE _____