ABC Children's Clinic Inc.

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DEMOGRAPHICS

PATIENT

Patient's Full Name: _____ Date of Birth: _____ Sex:□ Male □ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Primary E-Mail: _____

REQUIRED BY THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hawaiian Native or Pacific Islander □ White □ Declined to specify

Ethnicity: □ Unknown □ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify

PARENT/GUARDIAN

Father/Guardian: _____ Date of Birth: _____ □ Married □ Single □ Divorced □ Separated

SSN: _____ Driver's License: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Mother/Guardian; _____ Date of Birth: _____ □ Married □ Single □ Divorced □ Separated

SSN: _____ Driver's License: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Responsible Party Of Whom The Child Resides: _____

OTHER CHILDREN

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

EMERGENCY CONTACT

In case of emergency, whom should we contact? (Other than parent)

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE

When using private health coverage and Medi-Cal simultaneously, the private health coverage is billed first. After the private health carrier pays or denies a claim, Medi-Cal is then billed and will pay for services it covers.

Subscriber: _____

Primary: _____ □ PPO □ HMO □ MEDICAL If HMO or Medical, which group: _____

Secondary: _____ □ PPO □ HMO □ MEDICAL If HMO or Medical, which group: _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize ABC Children's Clinic Inc. to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. I authorize payment directly to ABC Children's Clinic Inc. for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance**. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits**. I also understand that I am responsible for advising ABC Children's Clinic Inc. of any all changes to my insurance. Payment of co-pays are due on date of service. **PLEASE SEE FINANCIAL POLICY.**

Signature: _____ Relationship: _____ Date: _____

A photocopy or scan or this authorization shall be considered as effective and valid as the original.