Glendale Pediatrics

Birth through 17 years of age

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

PLEASE LIST CHILDREN'S FULL LEGAL NAME: **TODAY'S DATE:**

Last Name	First Name	MI	Date of Birth		Current patients
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO

Are children's parents: ☐ **Married** ☐ **Separated** ☐ **Divorced Other:**_____

With whom does the child (children) primarily reside: _____

Name *Relationship*

Patient(s) Primary Address

Parents Name:	*Address:*	*#*	*City*	*State*	*Zip*

Patient(s) Secondary Address

Parents Name:	*Address:*	*#*	*City*	*State*	*Zip*

Parent or Legal Guardian Contact information: (Please list numbers in order of preference)

Name	***Relationship***	***Best contact number***	**H**	**C**	**W**	**OK to Leave msg**
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

1. Parent or Legal Guardian Information

Last Name:	First Name:		Relationship:
Date of Birth:	Last 4 of SS#:	Email address:	
Employer:		Occupation:	
Emp City:	Emp State:	Work number:	

2. Parent or Legal Guardian Information

Last Name:	First Name:		Relationship:
Date of Birth:	Last 4 of SS#:	Email address:	
Employer:		Occupation:	
Emp City:	Emp State:	Work number:	

IN CASE OF EMERGENCY, CONTACT: _____Phone:_____

(Person not living in same house)

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, xrays 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:_____