PEDIATRIC ASSOCIATES *California*
363 East Almond Avenue, Suite 105. Madera CA, 93637
Phone: (559) 673-6085 Fax: (559) 673-6087

PATIENT INFORMATION

(Please Print)

PATIENT NAME (First)	(Last)		
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER	MESSAGE PHONE NUMBER
PREFERRED PHARMACY/PHONE #		AUTHORIZED METHODS OF COMMUNICATION ☐ e-mail ☐ phone ☐ phone message ☐ message w realtive	
PARENTS INFORMATION			
MOTHER'S NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME PHONE	MOBILE PHONE	EMAIL ADDRESS	
FATHER'S NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME PHONE	MOBILE PHONE	EMAIL ADDRESS	
INSURANCE INFORMATION			
NAME OF INSURED OR RESPONSIBLE PARTY		DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		CITY	STATE / ZIP
RELATIONSHIP TO PATIENT		AUTHORIZED METHODS OF COMMUNICATION ☐ e-mail ☐ phone ☐ phone message ☐ message w realtive	
HOME PHONE	MOBILE PHONE	EMAIL ADDRESS	
EMPLOYER OF INSURED RESPONSIBLE PARTY		WORK PHONE NUMBER	
NAME OF PRIMARY MEDICAL INSURANCE		GROUP NUMBER	ID NUMBER

FINANCIAL AGREEMENT FOR ASSIGNED BENEFITS AND AUTHORIZATION FOR TREATMENTS:

I authorize Pediatric Associates California to examine, prescribe medication for, treat and/or perform diagnostic tests on the above mentioned patient. I also authorize my insurance benefits to be paid directly Pediatric Associates California and the release of information required for processing this claim. I am financially responsible for non-payment and non-covered services.

SIGNATURE		RELATIONSHIP TO PATIENT	DATE
PRINT NAME		ID#:	

Revised 06/11/2012

Verified by: ___________________