Kids Doc of Southern California Medical Group, Inc.

"Please Print Clearly"

Patient (Child's) Information:

Last Name:_____First Name:_____ Initial:_____

Date of Birth:____/____/____ Age:_____ Sex: Male Female

Primary Care Physician:_____

Parent/Responsible Party Information:

Father's Last Name:_____First Name:_____Initial:_____

Social Security #:_____ Date of Birth: ____/____/_____

Address: _____City: _____

State: _____ Zip: _____ Phone # (___)_____

Cell Phone # : (___)_____ Work Phone # : (___)_____

Mother's Last Name:_____First Name:_____Initial:_____

Social Security #:_____ Date of Birth: ____/____/____

Address: _____City: _____

State: _____ Zip: _____ Phone # (___)_____

Cell Phone # : (___)_____ Work Phone # : (___)_____

Primary Insurance Information:

Primary Insurance Plan Name:_____

ID Number:_____Group Number: _____

Name of Parent Child Insured Under: _____

Employer Name: _____

Secondary Insurance Information:

Secondary Insurance Plan Name:_____

ID Number: _____Group Number:_____

1. CONSENT TO TREATMENT. The undersigned consents to any medical or surgical treatment rendered to the above named patient that may be considered advisable and necessary in the judgment of the physician or nurse practitioner.
2. RELEASE OF INFORMATION. The undersigned agrees that Kid's Doc may release medical records or other information necessary to secure payment from insurance companies, health care service plans or Worker's Compensation carriers.
3. PAYMENT TERMS AND ASSIGNMENT OF BENEFITS. The undersigned authorizes payment to the above provider of benefits due me under any terms of any insurance policy or policies that may cover provider's professional services rendered to the above name patient. I understand that I am financially responsible to the provider for services not paid by said insurance policies. This responsibility includes services rendered but not authorized by the patient's health insurance plan or when the provider is not a contracted provider with the health insurance plan.

Signature Parent/Guardian:_____

Relationship to Patient: _____Date: _____