VALLEY PEDIATRIC MEDICAL GROUP, Inc.

Patient Registration Form

Primary Physician: _____ ACCT#: _____

Patient: _____ Sex: M F Birthdate: _____

Patient: _____ Sex: M F Birthdate: _____

Patient: _____ Sex: M F Birthdate: _____

Patient's Address: _____ Home Phone # _____

City _____ Zip _____ E-Mail: _____

Responsible Parent: _____ Relation to Patient: _____

Billing Address (if different than patient): _____

_____

Parent's Name: _____ Birthdate: _____ S.S#: _____

Parent's Employer: _____ Bus. Ph: _____ Cell. Ph: _____

Parent's Name: _____ Birthdate: _____ S.S#: _____

Parent's Employer: _____ Bus. Ph: _____ Cell. Ph: _____

In case of emergency, who should we contact? _____ Phone: _____

Referred By: _____

INSURANCE INFORMATION

Payment of copays and/or deductibles is due at the time service is rendered.

Insurance Company: _____ I.D.# _____ Group# _____

Subscriber: _____ Effective Date: _____

Second Insurance: _____ I.D.# _____ Group# _____

Subscriber: _____ Effective Date: _____

Authorization for Treatment and Assignment of Insurance Benefits.

I. the undersigned hereby authorize the Doctors and staff at Valley Pediatric Medical Group, Inc. to treat the medical condition(s) of my child(ren), and further authorize my signature below for use on any and all insurance claims submitted on our behalf for such services. I. hereby irrevocably accept financial responsibility for all medical and related services received while under medical care and assign any and all insurance benefits otherwise payable by the insurance company for said services. I. the undersigned understand that I am financialy responsible for any and all charges not covered by insurance, and further understand that payment for services received are due at the time service are rendered.

Signature of Parent or Guardian: _____ Date: _____

No Changes___Date_____

*****FILL IN ALL BLANK SPACES*****

No Changes___Date_____

VALLEY PEDIATRIC MEDICAL GROUP

5353 Balboa Boulevard
Suite 104
Encino, CA 91316
Telephone: (818) 789-7181
Fax: (818) 986-8322

Peter R. Shulman, M.D., F.A.A.P.
Marie T. Medawar, M.D., F.A.A.P.
Lynn S. Osher, M.D., F.A.A.P.
Louay Keilani, M.D., F.A.A.P.

WHO MAY WE SHARE MEDICAL INFORMATION WITH ON BEHALF OF YOUR CHILD?

CHILD'S NAME: _____ DOB: _____

PARENT(S) NAME: _____

SIBLING(S) NAME: _____

GRANDPARENT(S) NAME: _____

NANNY'S/BABYSITTER'S NAME: _____

SCHOOL: _____
(Indication of school specifically allows us to disclose medical information regarding immunizations/shots/and/or medications allowed to be administered during the school day).

OTHER: _____

OTHER: _____

WHERE MAY WE LEAVE MEDICAL INFORMATION REGARDING YOUR CHILD NAMED ABOVE?

HOME PHONE ANSWERING MACHING: **Y** OR **N** PHONE #_____

OFFICE VOICE MAIL: **Y** OR **N** PHONE #_____

CELL PHONE VOICE MAIL: **Y** OR **N** PHONE #_____

PARENT SIGNATURE: _____ DATE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the waiting room and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I am signing this Acknowledgement on behalf of all of my children that are treated at this medical practice.

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PRINT PATIENT NAME: _____

SIGNATURE: _____

DATE: _____ PHONE # _____

ACCOUNT #: _____

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Patient Preferred Contact Methods

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PHONE #: _____

TEXT MESSAGE #: _____

EMAIL: _____

	PHONE	TEXT	EMAIL
Medical Issues:	☐	☐	☐
Reminders:	☐	☐	☐
Recalls:	☐	☐	☐
Billing Statements:	☐	☐	☐
General Notices:	☐	☐	☐