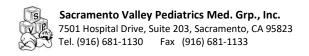




## **PATIENT REGISTRATION**

TODAY'S DATE:					
PATIENT'S NAME:				SEX: M/F	
BIRTHDATE: / /	AG	E:	SSN# -	-	
HOME ADDRESS:					
HOME PHONE#: MOBILE PHONE#:					
EMAIL ADDRESS:					
PREFERED LANGUAGE:	ETHNICITY:				
IF ABOVE IS NOT ENGLISH, DO YOU NEED AN INTERPRETER?  YES NO INITIAL HERE:					
MOTHER/GUARDIAN NAME:	BIRTHDATE:	FATHER/GUARDIA	N NAME:	BIRTHDATE:	
	/ /			/ /	
SS#:		SS#:			
HOME ADDRESS:		HOME ADDRESS:			
EMAIL:		EMAIL:			
HOME PHONE #:		HOME PHONE #:			
EMPLOYER:		EMPLOYER:			
EMPLOYER'S ADDRESS:		EMPLOYER'S ADDRESS:			
WORK PHONE #:		WORK PHONE #:			
		1			
PRIMARY INSURANCE		PHARMACY:			
COMPANY:		LOCATION:			
ID#					
GROUP #					

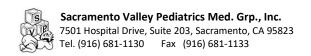
If on MediCal, please specify group assignment:



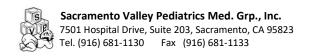


## **Medical History**

Patient's Name	Date of birth			
Mother's Name	Δσρ	Ocupation		
		Ocupation		
	Pregnancy an	nd Birth		
Mother's age at child's birth	_			
Did mom have any illnesses during pregnancy?		Yes No		
Did mom take any medications other than vitamins a		Yes No		
Was the baby full term or premature?				
What was the baby's birth weight?				
Did the baby have any breathing problems at birth?_				
While in the hospital did the baby have any medical If yes, what problem?		Yes No		
	Past Medical			
Where has your child gone for check-ups until now?		•		
Date of last check-up				
Has your child had allergic reactions to medication, f				
If yes, what kind?				
Has your child had any allergic reactions to immuniza		Yes No		
If yes, what kind?				
Any hospitalizations other than birth?		Yes No		
If yes, for what problem?				
Any serious injuries?		Yes No		
If yes, what kind?		<del></del>		
Are any medications taken regularly?		Yes No		
Which medications?				
Family History				
Are the child's parents both in good health?		Yes No		
Circle any diseases that this child's parents, grandpar				
		roblems cancer aids tuberculosis mental illness dr	ug	
problems inherited illness venereal diseases other	ſ			
Have any of your children passed away? Yes No	Reason			
	Feeding and N	lutrition		
Is your child's appetite usually good?	-	Yes No		
For the first 6 months did you breast of bottle feed?				
Does your child take vitamins?		Yes No		
	Review of sy	rstems		
Has your child had frequent ear infections?		Yes No		
Any eye problems?		Yes No		
Have any heart problems		Yes No		
Any problems with urination?		Yes No		
Blood problems?		Yes No		
Have problems with seizures or the nervous system?	)	Yes No		



Patient's name	Date of birth	
EMERGENCY	CONTACT INFORMATION:	
1. Name:	Phone Number	
Relationship to patient:		
2. Name:	Phone Number	
Relationship to patient:		
In case the parents cannot bring the checkild in for treatment? (Beside Parents)	ild to an appointment who would you authorize to bring	
1. Name	Date of birth	
Phone #	Relationship to patient	
2. Name	Date of birth	
Phone#	Relationship to patient	
Signed	Date	
Con	sent for Treatment	
son/daughter for any diagnostic proced	o Valley Pediatrics to render treatment to myself, my lures that are required. I understand that by signing this ancially responsible for any medical charges my non-covered items or services.	
Signature	Date	
Relationship to patient		



Patient Signature

## **Financial Responsibility Agreement**

The best medical practice is based on well-established communication and understanding between physician, parent and patient.

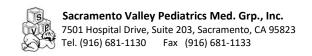
Our office policy requires payment in full at the time services are rendered. The person who brings the patient to their appointment is responsible for any charges unless other arrangements have been made with the office manager. If after 90 days the consultation is not paid for, there will be an additional \$20 charge and it will be sent to a collections agency.

Medi-Cal insurance benefit is VOID if a private (Commercial) insurance coverage is active at the time of service.

Failure to disclose the existence of private insurance benefit will result to billing problems and will hold patient responsible for the services incurred.

I hereby authorize my insurance to render payment to Sacramento Valley Pediatrics for services rendered.

I understand that if I must cancel an appointment, I will cancel it no later than the day before
my appointment. I understand there will be a \$25.00 fee for no show or same day cancellations
due before I can schedule my next appointment.
Initial
2 missed appointments without proper cancellation I will be given verbal warning. A 3rd no
show will automatically terminate me from SVP services, and I have 30 days to find a new
doctor.
Parent / Guardian (Please circle)
ratent / Guardian (riease circle)
Duint Mana
Print Name



Patient's Name	Date of birth					
Notice of Privacy Practices						
federal laws mandate that confidentiality of your heal	red the confidentiality of health information. Today, state and document that we have informed you of how we protect the information. this information is posted in our Notice and Privacind written copies are available at your request.	:y				
I have been advised of Sacramento Valley Pediatrics Notice of Privacy Practices.						
Parent/Patient Signature						
Date						