SACRAMENTO VALLEY PEDIATRICS
MEDICAL GROUP INC.
DBA: PEDIATRIC MEDICAL CENTER OF SACRAMENTO

Perla-Inez Maulino, MD, FAAP
Maria Nelisa Tan, MD, FAAP
Joan Villaflor, MD, FAAP
Lourdes Navea, PA

Alfonso Quant, PA
Dora Rodriguez, PA
Donald Neal, NP-C

Tel. (916) 681-1130
(916) 714-9777
Fax. (916) 681-1133
(916)714-9713

PATIENT REGISTRATION

TODAY'S DATE:	
PATIENT'S NAME:	**SEX: M / F**
BIRTHDATE: / /	**AGE:** **SSN# - -**
HOME ADDRESS:	
HOME PHONE#:	**MOBILE PHONE#:**
EMAIL ADDRESS:	
EMERGENCY CONTACT:	
TELEPHONE #:	

MOTHER/GUARDIAN: **BIRTHDATE: / /**	**FATHER/GUARDIAN:** **BIRTHDATE: / /**
SS#:	**SS#:**
HOME ADDRESS:	**HOME ADDRESS:**
HOME PHONE #:	**HOME PHONE #:**
EMPLOYER:	**EMPLOYER:**
EMPLOYER'S ADDRESS:	**EMPLOYER'S ADDRESS:**
WORK PHONE #:	**WORK PHONE #:**

PRIMARY INSURANCE	**PHARMACY INFO:**
COMPANY:	
ID#	**LOCATION:**
GROUP #	

If on MediCal, please specify group assignment:

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Medical History

Patient's Name_____Date of birth_____

Mother's Name_____Age_____Ocupation_____
Father's Name_____Age_____Ocupation_____

Pregnancy and 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 and iron? 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 problems? Yes No
If yes, what problem?_____

Past Medical History

Where has your child gone for check-ups until now?_____
Date of last check-up_____date of last dental exam_____
Has your child had allergic reactions to medication, foods, or insect bites? Yes No
If yes, what kind?_____
Has your child had any allergic reactions to immunizations? 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?_____
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, grandparents, brothers, sisters, aunts and uncles have had.
Anemia asthma allergies diabetes high blood pressure heart problems cancer aids tuberculosis mental illness drug problems inherited illness venereal diseases other_____
Have any of your children passed away? Yes No Reason_____

Feeding and Nutrition

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 systems

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

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Patient's name_____ Date of birth _____

In case of emergency who would you like us to call if parents are not available?

Name/Relationship_____ Phone Number _____

In case you cannot bring your child to an appointment who do you authorize to bring child in for treatment? (Beside Parents)

Name_____ Date of birth_____

Phone #_____ Relationship to patient_____

Name_____ Date of birth_____

Phone#_____ Relationship to patient_____

Signed_____ Date_____

In case of any changes please notify us immediately to update our file.

Consent for Treatment

I hereby give my consent to Sacramento Valley Pediatrics to render treatment to myself, my son/daughter for any diagnostic procedures that are required. I understand that by signing this disclaimed statement, I will be held financially responsible for any medical charges my insurance company denies because of non-covered items or services.

Signature _____ Date_____

Relationship to patient _____

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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)

Print Name _____

Patient Signature _____ Date _____

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Patient's Name _____ Date of birth _____

Notice of Privacy Practices

Physicians have always protected the confidentiality of health information. Today, state and federal laws mamdate that we document that we have informed you of how we protect the confidentiality of your health information. this information is posted in our Notice and Privacy Practices in the waiting room and written copies are available at your request.

I have been advised of Sacramento Valley Pediatrics Notice of Privacy Practices.

Patient Signature _____

Date _____