PATIENT INFORMATION FORM

Account #: _____

Please list all children in the family.

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Name: _____ ☐ M ☐ F DOB:____/____/____ Name: _____ ☐ M ☐ F DOB:____/____/____

Home Address: _____
Street City State Zip

PRIMARY: (_____)_____-_____ Secondary: (_____)_____-_____ Email: _____

EMERGENCY CONTACT: _____ Phone: (_____)_____-_____
Name

I authorize Beach Pediatrics to leave messages or send text messages at the primary number listed above regarding my child's health information, appointments, test results, and billing unless otherwise specified. ☐ Yes ☐ No

I authorize Beach Pediatrics to email me at the email address listed above regarding my child's health information, appointments, and test results unless otherwise specified. ☐ Yes ☐ No

Please select all that apply *(optional)*: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ Asian

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Cell: (_____)_____-_____ Work: (_____)_____-_____

Occupation: _____ Employer: _____

Please circle one. **Mother / Father / Guardian**

Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Cell: (_____)_____-_____ Work: (_____)_____-_____

Occupation: _____ Employer: _____

Parents of the child/children are: ☐ Single ☐ Married ☐ Divorced ☐ Separated

If the parents are divorced or separated, what are the legal custody arrangements for the child/children? ☐ Sole ☐ Joint

If sole legal custody, please provide legal documentation to be scanned into patient(s)'s chart.

CAREGIVER AUTHORIZATION — I, the parent/guardian, give authorization to the following relatives and/or caregivers to bring my child/children in for sick visits, testing and/or treatment which is recommended and provided by the physicians and staff of Beach Pediatrics. **This Authorization will remain in effect until further written notice.**

Name/Relationship:_____ Name/Relationship:_____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Name of Subscriber: _____

ID#: _____

Group #:_____

PHARMACY

Name: _____ Location/Zip:_____ Phone: (_____) _____-_____

I declare the information I provided above is correct, and if there are any changes, I will notify Beach Pediatrics.

Parent/Guardian Signature: _____ Date: _____/_____/_____

Beach Pediatrics
Office Policies

Child's Full Name _____ DOB: _____

Please initial each line to indicate that you understand and agree. If you have any questions, please ask.

_____ **Insurance Coverage:** Your insurance policy is a contract between you and your insurance company. We verify benefits as a courtesy but cannot guarantee coverage or payment.

_____ **Insurance Updates:** You are responsible for providing current insurance information. You may be responsible for charges if your insurance information is not up to date.

_____ **Billing Communication:** We will submit claims to your insurance and send statements for any remaining balance.

_____ **Appointment Cancellations / No Shows:** Please cancel at least 24 hours in advance. A $50 fee may apply for missed or late-canceled appointments.

_____ **Late Arrivals:** Arriving more than 15 minutes late may require rescheduling, though we will make reasonable efforts to accommodate you.

_____ **Medical Records:** Medical records are available upon written request. Reasonable fees may apply in accordance with California law.

_____ **Authorization to Treat Minors:** A parent or legal guardian must consent to treatment. Written authorization is required if another adult brings your child.

Acknowledgement & Consent

I have read and understand the office policies.

I acknowledge that I have signed a separate **Patient Financial Agreement** and accept responsibility for charges as outlined in that agreement.

I have received and understand the Notice of Privacy Practices. I consent to the use and disclosure of my child's health information for treatment, payment, and healthcare operations.

Printed Name: _____ Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____

Patient Financial Agreement

Child's Full Name _____ DOB: _____

1. Insurance & Payment Responsibility

- We bill your insurance as a courtesy.
- You are responsible for all charges not paid, including copays, deductibles, and non-covered services.
- Payment is due at the time of service unless prior arrangements are made.

2. Billing & Statements

- Statements are issued for any remaining balance and are due within **30 days**.
- Balances over 30 days may accrue interest at a rate of up to 10% per year as allowed by California law.
- You may request an itemized bill at any time.

3. Financial Assistance / Payment Plans

- Contact us promptly if you are unable to pay your balance.
- Unpaid accounts without communication may be sent to collections.

4. Collections

- Accounts with no payment or communication may be referred to a collection agency.
- You remain responsible for the balance owed under California law.

5. Required California Medical Debt Disclosure (SB 1061)

NOTICE TO CALIFORNIA PATIENTS:
A holder of this medical debt contract is prohibited by Section 1785.27 of the California Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

6. Additional Terms

- A fee may be applied for returned payments.
- The parent or legal guardian accompanying a minor is responsible for payment.

7. Acknowledgment & Agreement

I have read and understand this policy and agree to be financially responsible for all charges.

Printed Name: _____ Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____

New Patient Intake Form

Patient Information

Child's Name: _____ DOB: _____ Gender: ☐ M ☐ F

Pregnancy & Birth History

Mother's Name: _____ Mother's age at birth: _____

Father's Name: _____ Father's age at birth: _____

Pregnancy complications: ☐ Yes ☐ No If yes, please describe: _____

Delivery type: ☐ Vaginal ☐ C-section, reason: _____

Birth weight: _____ Birth length: _____ ☐ Full-term ☐ Preterm # weeks: _____

Problems immediately after birth (check all that apply):

☐ Jaundice ☐NICU stay ☐Infection ☐Feeding problems Other: _____

Medical History

Current medications (include supplements): _____

Allergies (medications, foods, environment): _____

Past problems, hospitalizations, surgeries, or serious illnesses (with dates): _____

_____

Developmental History

Delayed Milestones: ☐ Yes ☐ No If yes, please describe: _____

Any developmental concerns? ☐ Yes ☐ No If yes, explain:_____

Family Medical History

(Mark for each relative if present — condition — age if alive or age at death)

Relative	Condition(s)	Age
Mother	_____	_____
Father	_____	_____
Sibling(s)	_____	_____
Grandparents	_____	_____

Social History & Environment

Primary caregiver(s): _____

Daycare/School attendance: ☐ Yes ☐ No If yes, name or setting: _____

Smoking exposure? ☐ Yes ☐ No Pets at home? ☐ Yes ☐ No If yes, specify: _____

Completed by: _____ **Date:** _____

Physician Signature: _____ **Date:** _____