Account # _____

DIABLO VALLEY PEDIATRICS MEDICAL GROUP
REGISTRATION INFORMATION

PATIENT INFORMATION:

Patient's Name: _____ Patient's Date of Birth ____/____/____
Patient's Home Address: _____ Male: _____ Female:_____
City: _____ State: _____ Zip Code: _____
Preferred Phone Number: _____ Alternate Phone Number: _____
Email: _____
Patient lives with: Both Parents _____ Mother _____ Father _____ Other _____

GUARANTORS INFORMATION:
MOTHER:
Name: _____ Relationship to Child_____
Date of Birth: _____ Social Security # _____
Address Same As Above Yes / No
Home Address: _____ Mailing Address:_____
City: _____ State: _____ Zip: _____
Employer: _____

FATHER:
Name: _____ Relationship to Child_____
Date of Birth: _____ Social Security # _____
Address Same As Above Yes / No
Home Address: _____ Mailing Address:_____
City: _____ State: _____ Zip: _____
Employer: _____

INSURANCE INFORMATION:
Primary Insurance: _____
Policy Holder: _____ Date of Birth _____
Relationship to Child _____
ID# _____

Secondary Insurance: _____
Policy Holder: _____ Date of Birth _____
Relationship to Child _____
ID# _____

I hereby authorize my physician consent to the examination and/or treatment of my child during the office visits. The authorization includes but not limited to any necessary lab work, procedures as well as the administration of any recommended immunizations. A photocopy of this agreement is considered as valid as an original. This agreement will remain in effect until revoked by me in writing. I acknowledge that the above information is correct.

I have been given a copy of Diablo Valley Pediatrics Medical Group Inc., Financial Policy and Notice of Privacy Practices.

Signature: _____ Date: _____