



South Coast Pediatrics
Patient Information Form

NOTE – If you have more than one child, please complete the family related information first. Copies will then be made to complete the information specific to each patient.

First Name: _____ Last Name: _____ Middle Initial: _____
 Date of Birth: ____/____/____ Gender: ____ Male ____ Female Patient's Cell Phone: (____) ____-____
 Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown
 American Indian Asian Black or African American Native Hawaiian
 Other Other Pacific Islander Not Hawaiian Asian Unknown White

FAMILY INFORMATION BELOW

Home Address: _____
 Street City State Zip
 Primary: (____) ____-____ Secondary: (____) ____-____ Emergency Contact: _____ (____) ____-____
 I authorize the practice to leave detailed messages @ the #s listed above regarding my child's health, appointments, test results and billing unless otherwise specified here:

Please circle one. Mother/Father/Guardian: _____ Address (if different from patient's): _____ Cell Phone: (____) ____-____ Email: _____ Employer: _____ Last 4 digits of SSN: _____ Birthday: ____/____/____	Please circle one. Mother/Father/Guardian: _____ Address (if different from patient's): _____ Cell Phone: (____) ____-____ Email: _____ Employer: _____ Last 4 digits of SSN: _____ Birthday: ____/____/____
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Are parents of the child/children: Married Divorced Living Together Separated
 IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THE CHILD/CHILDREN?
 Physical Custody – Name: _____ Relationship to Patient: _____
 Legal Custody: Sole Joint – Name(s): _____ Relationship to Patient: _____
***If sole legal custody, please provide legal documentation to be scanned into patient's chart.**

Caregiver Authorization: The following qualified relatives and/or caregivers have permission to seek care on behalf of my child **or myself (adult over 18)**, which includes immunizations physical exams, testing and/or treatment, for the purpose of medical diagnoses and medical care, which is deemed advisable and is to be rendered by the providers and staff.
 *The Caregiver's Authorization Affidavit will remain in effect until further written notice.
 Name/Relationship to Patient: _____
 Name/Relationship to Patient: _____

Primary Insurance Information Insurance Name: _____ Name of Subscriber: _____ ID#: _____ Group #: _____	Secondary Insurance Information Insurance Name: _____ Name of Subscriber: _____ ID#: _____ Group #: _____
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Sibling(s)'s Names/Date of Birth

I declare the information I provided above is correct and if there are any changes, I will notify the office immediately.
 Name/Signature: _____ Date: _____