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: ____/____/____

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 #: _____

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: _____

SOUTH COAST PEDIATRICS

Acknowledgement of Receipt for Notice of Privacy Practices

I hereby acknowledge that South Coast Pediatrics (SCP) has the **Notice of Privacy Practices** posted in the reception area. I understand that SCP may share my child's health information for treatment, billing and healthcare options. I have seen the Notice of Privacy Practices that describes how my health information is used and shared. I understand that SCP has the right to change/update this notice at any time and if I wish to obtain a copy I can request one from the receptionist.

Patient Name (Printed)	Date of Birth
Signature of Parent, Legal Representative or Patient (over 18 years of age)	Date

If not signed by the patient, please indicate relationship: _____