SOUTH EAST BAY PEDIATRIC MEDICAL GROUP, INC.
2191 MOWRY AVE., SUITE 600-C • FREMONT, CALIFORNIA 94538

PATIENT INFORMATION

HEALTH PLAN ELIGIBILITY CERTIFICATION:

I am aware that if my child is not eligible for benefits under the terms of coverage of my insurance plan at the time of service or if my insurance does not pay or if the services provided are not covered under my plan, I am responsible for all charges related to the services provided.

Consent: I authorize any physician of SOUTH EAST BAY PEDIATRIC MEDICAL GROUP, Inc., to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, and/or diagnostic procedures, including X-ray or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

Authorization to release information: I hereby authorize SOUTH EAST BAY PEDIATRIC MEDICAL GROUP to release any information acquired in the course of my or my child's examination or treatment to insurance companies or others as designated by me.

Authorization to pay benefits to physician: I hereby authorize payment directly to SOUTH EAST BAY PEDIATRIC MEDICAL GROUP for any medical services provided.

Acknowledgement of missed appointment policy: I understand that I will be charged a fee for any missed appointments.

Acknowledgement of telephone advice policy: I understand that there will be a charge for telephone advice provided outside of normal clinic hours. I understand that I am responsible for payment of this charge if said service is not a covered benefit of my insurance plan.

PATIENT'S NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

INSURED NAME _____ RELATION TO CHILD _____ SOC. SEC. # _____ BIRTH DATE _____

HOME / MAILING ADDRESS _____
Street Apt # City Zip Code

Cell Phone _____ ☐ OK to leave detailed message ; Home Phone _____ ☐ OK to leave detailed message Family Email _____

EMPLOYED BY _____ WORK PHONE _____

OTHER PARENT NAME _____ RELATION TO CHILD _____ BIRTH DATE _____

EMPLOYED BY _____ CELL PHONE _____ ☐ OK to leave detailed message

PRIMARY INSURANCE COMPANY: _____

ID # _____ GROUP # _____ PHONE # OF INSURANCE CO. _____

NAME OF SUBSCRIBER _____ RELATION TO CHILD _____

SECONDARY INSURANCE COMPANY: _____

ID # _____ GROUP # _____ PHONE # OF INSURANCE CO. _____

NAME OF SUBSCRIBER _____ RELATION TO CHILD _____

Signature of Parent _____ **Date** _____ **Relationship** _____