



Capitola Pediatrics

Patient Registration

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831-476-1933 Office 831-476-2677 Fax

Name: Last _____ First _____ Middle _____ Birth date: ____/____/____ Age _____ Sex _____ SSN _____

Main Address _____	Parent at the main address _____
City, State, Zip _____	Parent at the second address _____
Phone Numbers _____	Responsible for Billing _____
Second Address _____	Billing Address _____
City, State, Zip _____	City, State, Zip _____
Phone Numbers _____	Phone Numbers _____

Mother/Coparent: _____ Birth date: ____/____/____ SS#: _____
 Calif. Driv. Lic.: _____ Employer: _____ Work Phone: _____

Father/Coparent: _____ Birth date: ____/____/____ SS#: _____
 Calif. Driv. Lic.: _____ Employer: _____ Work Phone: _____

Parent's Marital Status: Married Divorced Separated Single Widow/Widower

Religion (Optional): _____

PRIMARY INSURANCE CO.: _____ Group Name/Number: _____
 Policy Holder: _____ Birth Date: ____/____/____ Member #: _____
 Claims Address: _____ Ins. Phone: _____

SECONDARY INSURANCE CO.: _____ Group Name/Number: _____
 Policy Holder: _____ Birth Date: ____/____/____ Member #: _____
 Claims Address: _____ Ins. Phone: _____

Who is your child's main Medical Care Provider at this office? _____

Referred by: Friend/Physician _____ Other _____
 Article/Announcement _____ Yellow Pages _____

School/Day Care Attending: _____

Siblings (Full Names) and Ages: _____

In case of emergency notify: _____ Phone Number: _____
 (Neighbor, Grandparent, Friend)

I hereby authorize my insurance company to pay any benefits due in regards to my child's medical treatment directly to Capitola Pediatrics providers. I authorize Capitola Pediatrics to release to my insurance company, if necessary, my child's medical records. I understand that I am responsible for all charges incurred for my child, regardless of any medical insurance I have.

SIGNED: _____ RELATIONSHIP: _____ DATE: ____/____/____