



# CAPITOLA PEDIATRICS PATIENT REGISTRATION

Elizabeth Baskerville, M.D.  
Bruce Block, M.D.  
Raelene Walker, M.D.

Jim Bennett, M.D.  
Sara Liu, M.D.

4145 Clares Street, Suite A  
Capitola, CA 95010  
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 Number \_\_\_\_\_

**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: \_\_\_\_\_

Your Child's Primary Care Provider at this office (Doctor, Nurse Practitioner, Physician Assistant): \_\_\_\_\_  
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, and I understand that all charges are to be paid in full within 45 days of treatment.

SIGNED: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_