

# Monterey Peninsula Pediatric Medical Group

We need to update our records. Thank you for printing clearly.

## PATIENT INFORMATION

Name (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last) \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
Preferred Language English \_\_\_ Other \_\_\_\_\_  
Emergency Contact 1. (Other than parent) \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
Emergency Contact 2. (Other than parent) \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**\*To authorize consent for treatment, please complete attached Consent Form.**

## 1. PARENT/GUARDIAN INFORMATION

\_\_\_ Mother \_\_\_ Father Biological parent (Circle one) Yes / No \_\_\_ Legal Guardian \_\_\_ Foster Parent \_\_\_ Step Parent  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Consent to text (Circle one) Yes / No  
Email \_\_\_\_\_ Social Security Number \_\_\_\_\_

## 2. PARENT/GUARDIAN INFORMATION

\_\_\_ Mother \_\_\_ Father Biological parent (Circle one) Yes / No \_\_\_ Legal Guardian \_\_\_ Foster Parent \_\_\_ Step Parent  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Consent to text (Circle one) Yes / No  
Email \_\_\_\_\_ Social Security Number \_\_\_\_\_

## ADDITIONAL CHILDREN

Please list the names of other children seen in our office:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_

## H.I.P.A.A. NOTIFICATION

I acknowledge receipt of Monterey Peninsula Pediatric Medical Group's notice of Privacy Practice and Patients' Rights effective 4/14/03.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO EXAM AND TREATMENT

I give consent to have my child(ren) evaluated and treated by Monterey Peninsula Pediatric Medical Group and its associates. The above information is accurate and complete to the best of my knowledge.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_