Coastal Pediatric Medical Group, Inc.

Pediatric and Adolescent Medicine

451 W Gonzales Rd., Suite 340
Oxnard, CA 93036
(805) 983-3900

100 N. Brent St., Suite 102
Ventura, CA 93003
(805) 643-9271

Patient Information

Name _____

Home Address _____

City _____

State _____ ZIP _____

Home Phone _____

Date of Birth _____

Sex (M/F) _____ Age _____

Preferred Language English/Spanish/Other
(Circle One)

Father/Guardian _____

Address _____

City _____

State _____ ZIP _____

Home Phone _____ Cell _____

Date of Birth _____ SS # _____

E-Mail _____

Employer _____

Business Address _____

City _____

State _____ ZIP _____

Work Phone _____

Occupation _____

Mother/Guardian _____

Address _____

City _____

State _____ ZIP _____

Home Phone _____ Cell _____

Date of Birth _____ SS # _____

E-Mail _____

Employer _____

Business Address _____

City _____

State _____ ZIP _____

Work Phone _____

Occupation _____

Medical Insurance Information For Child

Insurance Company _____

Phone Number _____

Type of Insurance (Circle One) HMO / PPO

Subscriber Name _____

Relationship to Patient _____

I.D. Number _____

Group Number _____

Eff. Date _____ Copay _____

Child's Primary Care M.D. _____

List names of siblings (first and last names)

_____

_____

_____

_____

Referred By _____

In Case Of Emergency

Emergency Contact _____

Phone Number _____

Authorization to Pay Benefits to Physician

I hereby authorize payment directly to Coastal Pediatric Medical Group, Inc. for services rendered or supplies provided. I understand that I am responsible for paying any amount not covered by my child's primary insurance.

Coastal Pediatrics does not bill secondary insurances.

Authorization to Release Medical Information

I hereby authorize release of any medical or other information necessary to process any claims.

Payment Terms

Cash payment or proof of insurance is required at time of service. Co-pay must be paid before seeing the doctor.

Signature _____

Date _____