Patient Information:

____ Sex: ________

(Last Name) (First Name) Middle)

Birth Date: ____/____/____ Age: ________ Social Security ________________

Street Address ____________________ City/State: ______________ Zip: ________

Home #: ________________ Daytime # ________________ Cell# ________________

Mothers Information:

____ ________________

(Last Name) (First Name) (Middle) Date of Birth

Social Security: ____________________ Marital Status: Married/Divorced/Single/Widowed

Street Address: ____________________ City/State: ______________ Zip: ________

Employment Status: Full time/Part time/Student/Unemployed

Employer Name/Address: ________________________________

Work Phone: ____________ Daytime/Cell #: ____________ Home # ____________

Fathers Information:

____ ________________

(Last Name) (First Name) (Middle) Date of Birth

Social Security: ____________________ Marital Status: Married/Divorced/Single/Widowed

Street Address: ____________________ City/State: ______________ Zip: ________

Employment Status: Full time/Part time/Student/Unemployed

Employer Name/Address: ________________________________

Work Phone: ____________ Daytime/Cell#: ____________ Home#: ____________

Emergency Contact (Who may we contact in the event of an emergency)

________________ ________________ ________________

Name Relationship Phone #

Insurance Information:

________________ ________________ ________________

Insurance Company ID# Group #

Relationship to the Insured: Self/Spouse/Child/Other

________________________________ ________ ________

Policy Holder Last Name First Middle Sex Date of Birth

________________ ________________ ________

Insurance Co. Address City/State Zip

I authorize the release of any medical records necessary to process insurance claims.

Patient/Legal Guardian Signature: ________________________ Date: ________

I authorize the release of payment for medical benefits to Sindu Pillai, M.D, dba Inland Valley Pediatrics.

Patient/Legal Guardian Signature: ________________________ Date: ________

I hereby give permission for Sindu Pillai, M.D., dba Inland Valley Pediatrics to render necessary medical treatment to the above named minor of which I am the parent or legal guardian.

Parent/Legal Guardian Signature: ________________________ Date: ________