Welcome to Pediatrics West

Thank you for choosing our practice. All Information will be STRICTLY CONFIDENTIAL.

Today's Date:_____

Patient's Name:_____ Date of Birth :_____

(Last) (First) (MI)

Race: (circle one) Asian Black/African American Caucasian Chinese Hispanic Japanese

American Indian or Alaska Native Latino Multiracial Pacific Islander Other

Ethnicity: (circle one) Hispanic Non Hispanic White Other

Language: (circle one) English French German Hindi Mandarin Spanish Vietnamese Other

Street Address:_____ Sex: M F

City: _____**State:** _____ **Zip Code:**_____

Mailing Address: (if different from street address)_____

Home Phone: _____ Patient's Cell (if>13yo)_____

E-MAIL:_____

Mother/Guardian's Name: _____Father/Guardian's Name:_____

Relationship to Child: _____ Relationship to Child:_____

Date of Birth: _____ Date of Birth:_____

Work/Cell Phone:_____ Work/Cell Phone:_____

Patient's Primary Care Doctor (as listed with Insurance company)_____

Sibling(s) Name(s) and Date(s) of Birth_____

PERSON RESPONSIBE FOR BILL: (must be parent/guardian)

Name:_____

Address: (if different from above)_____

City: _____**State:** _____**Zip Code:** _____

Phone: _____ **SS#**_____

Insurance Information: (patients are required to show insurance cards at all visits)

Mother/Guardian_____DOB:_____Insurance Co :_____

Insurance ID#_____ Group# _____ Copay_____

Address (If different from above)_____

Father/Guardian_____DOB:_____ Insurance Co: _____

Insurance ID# _____Group#_____Copay_____

Address (If different from above)_____

Who referred you to our office?_____

Signature:_____