Sea View Pediatrics

Serving Orange County Since 1973

A member of CHOC Children's Network

PATIENT INFORMATION

NAME: _____ Nickname: _____

Birth Date: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

FATHER'S NAME: _____	MOTHER'S NAME: _____
Birth Date: _____	Birth Date: _____
Home Address: _____ (If different than child)	Home Address: _____ (If different than child)
City: _____ Zip: _____	City: _____ Zip: _____
Driver's License #: _____	Driver's License #: _____
Social Security #: _____ (For Insurance Purposes Only)	Social Security #: _____ (For Insurance Purposes Only)
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
Email Address: _____	Email Address: _____
Mobile Number: _____	Mobile Number: _____

Emergency Contact (other than parent)

Name: _____

Relation: _____ Number: ( ) _____ - _____

Referred by: _____

Siblings Names	Birth Date
_____	_____
_____	_____
_____	_____

Authorization

I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and I irrevocably assign to the doctor all payments for medical services rendered. I understand that I am ultimately responsible for all charges including those not paid for by insurance.

Notice to consumers: Medical doctors are licensed and regulated by the Medical Board of California: (800) 633-2322 www.mbc.ca.gov

Parent Signature: _____ Date: _____