EDINGER MEDICAL GROUP

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ MI: _____

Name Your Child Prefers: _____ Date of Birth: _____ Sex: ○M ○F

Address: _____ City: _____ State: _____ Zip: _____

PARENT INFORMATION

Parent's Name:_____ SSN: _____

DOB: _____ Sex: ○M ○F Email Address*: _____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: ○_____ Cell Phone: ○_____ Work Phone: ○_____

(Please check preferred phone number for contact and messages)

Employer: _____ Occupation: _____

Second Parent's Name:_____ SSN: _____

DOB: _____ Sex: ○M ○F Email Address*: _____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: ○_____ Cell Phone: ○_____ Work Phone: ○_____

(Please check preferred phone number for contact and messages)

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Comp. Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Subscriber/ID #: _____

Group/Plan #: _____

Secondary Insurance

Insurance Comp. Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Subscriber/ID #: _____

Group/Plan #: _____

Please list names of minor children living at home:

Name: _____ ○M ○F DOB: _____ Name: _____ ○M ○F DOB: _____

Name: _____ ○M ○F DOB: _____ Name: _____ ○M ○F DOB: _____

Emergency Notification

Name:_____ Relationship:_____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

I (we) the undersigned parent, parents, or legal guardian of a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician of the Edinger Medical Group, Inc., licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment, but that any of the above will not be withheld if the undersigned cannot be reached.

This authorization if given pursuant to the provisions of section 25.8 of the Civil Code of California.

I hereby authorize Edinger Medical Group to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments for medical services rendered to my dependents or myself to Edinger Medical Group. I understand that I am responsible for any amount not covered by insurance. Initial: ____

Signature: _____ Date: _____

*For appointment reminders, announcements, and upcoming events only

EDINGER MEDICAL GROUP

PEDIATRIC PATIENT REGISTRATION
ADDITIONAL INFORMATION

Please take a moment to fill in the information below to populate our electronic medical records system. This information will be required one time. However; if your preferred pharmacy selection changes, we ask you to update our office as soon as possible.

Thank you.

Patient Name: _____

Language: (Please select your primary language)

○ English ○ Spanish ○ Chinese ○ Vietnamese ○ Arabic ○ Other: _____

Ethnicity of Child: (Please make one selection)

○ Hispanic or Latin ○ Not Hispanic or Latin ○ Refused to Respond

Race of Child: (Please make one selection)

○ White ○ Hispanic ○ Black or African American
○ Asian ○ Native Hawaiian ○ Other Race:_____
○ Other Pacific Islander ○ Unreported/Refused to Report

How did your child become a patient at Edinger Medical Group?

☐ Family/Friend ☐ Health Plan Website/Directory ☐ Web Site ☐ Advertisement
☐ Other: _____

Pharmacy Information

Name of **Primary** Pharmacy: _____

Street Address: _____ Major Cross Streets: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Name of **Secondary or Mail in** Pharmacy: _____

Street Address: _____ Major Cross Streets: _____

City: _____ State: _____ Zip: _____

Phone Number: _____