### **Castro Valley Pediatrics**

Your Doctor(circle): Carim Hiramatsu Johnston Sehdev Vance

**PLEASE PRINT NEATLY**

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| --- |
| PATIENT INFORMATION |
| **Child #1** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
| **Ethnicity****Preferred Language** | **□Non-Hispanic □Hispanic** **□English □Spanish □\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Race** | **□African American****□Asian****□Native American/Native Alaskan****□ Caucasian****□Pacific Islander****□Other**  |  |  |  |  |
| **Child #2** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
| **Ethnicity** | **□Non-Hispanic □Hispanic**  | **Race** | **□African American****□Asian****□Native American/Native Alaskan****□ Caucasian****□Pacific Islander****□Other**  |  |  |  |  |
| **Child #3** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
| **Ethnicity** | **□Non-Hispanic □Hispanic**  | **Race** | **□African American****□Asian****□Native American/Native Alaskan****□ Caucasian****□Pacific Islander****□Other**  |  |  |  |  |
| **Child #4** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
| **Ethnicity** | **□Non-Hispanic □Hispanic**  | **Race** | **□African American****□Asian****□Native American/Native Alaskan****□ Caucasian****□Pacific Islander****□Other**  |  |  |  |  |

PARENT/GUARDIANS

|  |
| --- |
| **Parent # 1 Relation to Guarantor: Self ☐ Spouse** **☐ Child** **☐ Other** **☐** |
| **Last Name** |  | **First Name** |  | **MI** |  | **Home Phone** | **( )** |
| **Address** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Cell Phone** | **( )** | **Work Phone** | **( ) Ext.** |
| **Marital Status** |  | **Social Security Number** |  |
| **Employer** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
| **Email Address** |  |
|  |  |
| **Contact me (check all that apply):** | **Text** **☐**  | **Phone** **☐** | **Email** **☐** |  |  |  |
| **Parent # 2 Relation to Guarantor: Self ☐ Spouse ☐ Child ☐ Other ☐** |
| **Last Name** |  | **First Name** |  | **MI** |  | **Cell Ph#** | **( )** |
| **Address** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Home Phone** | **( )** | **Work Phone** | **( ) Ext.** |
| **Marital Status** |  | **Social Security Number** |  |
| **Employer** |  | **Date of Birth** |  | **Age** |  | **Sex** | **M / F** |
|  |  |  |  |  |  |  |  |
| Insured (Policyholder) Information --- Primary Carrier Please present your insurance card(s) to front desk. |
| **Insurance Co Name:** |  | **Policy #** |  |
| **Address** |  | **Group #** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Patient’s Relation to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐** |
| **Policy Holder’s Name** |  | **Address** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Telephone** | **( )** | **Date of Birth** |  | **Sex: Male** **☐ Female** **☐** |
| **Employer:** |  |
| Insured (Policyholder) Information --- Secondary Carrier Please present your insurance card(s) to front desk. |
| **Insurance Co Name:** |  | **Policy #** |  |
| **Address** |  | **Group #** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Patient’s Relation to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐** |
| **Policy Holder’s Name** |  | **Address** |  |
| **City** |  | **State** |  | **Zip** |  |
| **Telephone** | **( )** | **Date of Birth** |  | **Sex: Male ☐ Female ☐** |
| **Employer:** |  |
|  |

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to Castro Valley Pediatrics. I understand payment is due at time of services.

Signature of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at [https://openpaymentsdata.cms.gov.](https://openpaymentsdata.cms.gov./)”