### **Castro Valley Pediatrics**

Your Doctor(circle): Carim Hiramatsu Johnston Sehdev Vance

**PLEASE PRINT NEATLY**

### 

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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./)”