

SIMI PEDIATRIC PARTNERS

Stewart Brooks, MD Lauren Tashman, MD Yale Doberne, MD

Phone: (805) 527-9400 Fax: (805) 582-1344

Patient's name: _____ Birthdate: _____ Age: _____ Sex: _____

Family Members (include parents and siblings)

First Name	Last Name	Date of Birth	Age	Sex

Address _____ City _____ Zip _____

Phone Numbers (please circle cell, home, or work and note relation to patient next to contact number)

Primary: (C, H, W)

Alternate 1: (C, H, W)

Alternate 2: (C, H, W)

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Marital Status of parents: Married Single Divorced

Insurance Policy Holder Address (if different from above) _____

Father's Employer _____ Phone # _____

Mother's Employer _____ Phone # _____

Last 4 digits SS# Father _____ Father's Driver's License # _____

Last 4 digits SS# Mother _____ Mother's Driver's License # _____

Emergency Contact _____ Phone# _____ Relationship _____

Who referred you to this office? _____

TREATMENT AUTHORIZATION

I do hereby authorize the physicians of Simi Pediatric Partners to administer medical treatment to my child(ren) in my absence. I agree to assume all of the financial responsibility if I have no insurance, and all of the responsibility required by my insurance company if I do have insurance.

Parent's Signature _____ Date _____

INFORMATION AUTHORIZATION

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment.

Parent's Signature _____ Date _____