



Almaden Pediatrics Patient Information Form

Dr. Pete Dr. Michelle

Patient Information

First and Last Name (please list names of all siblings in the family)	Sex	Birth date
1. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___ / ___ / _____
2. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___ / ___ / _____
3. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___ / ___ / _____
4. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___ / ___ / _____
5. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___ / ___ / _____

Parent or Guardian Information

Responsible Party Name _____	Other Parent or Guardian _____
Relationship to Patient _____	Relationship to Patient _____
Birth date ___ / ___ / _____ SS# ___ - ___ - _____	Birth date ___ / ___ / _____ SS# ___ - ___ - _____
Address _____	Address _____
City _____ State ___ Zip _____	City _____ State ___ Zip _____
Occupation _____	Occupation _____
Home Phone (_____) _____ - _____	Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____ Ext. _____	Work Phone (_____) _____ - _____ Ext. _____
Cell Phone (_____) _____ - _____	Cell Phone (_____) _____ - _____
Email Address _____	Email Address _____
Patient(s) Lives With _____	Referred by _____

Emergency Contact Information

In an emergency please contact (other than above) _____
 Relationship _____ Phone (_____) _____ - _____

Consent for Use and/or Disclosure of Information: I hereby give consent to Almaden Pediatrics, Inc to use and disclose my protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we, or others have acted in reliance upon this consent.

Parent/ Guardian Signature _____ Date ___ / ___ / _____