

# South Bascom Pediatrics, Inc.

Patricia Ferrari, MD, PhD  
Mary Beth Hughes, MD  
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## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Best Daytime Contact & Message Number (Parent) \_\_\_\_\_ (Circle one: Cell Work Home)

Is English the primary language? \_\_\_\_ Interpreter needed? \_\_\_\_ If yes, specify language \_\_\_\_\_ Hearing impairment? \_\_\_\_

Names of Siblings & Birthdates (List all): \_\_\_\_\_

How did you choose our office? \_\_\_\_\_ My Child's Doctor is: \_\_\_\_ Dr. Ferrari \_\_\_\_ Dr. Hughes \_\_\_\_ Dr. Strickland

## RESPONSIBLE PARTIES

Father \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Mother \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Legal Guardian of Child (if not both parents) \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work \_\_\_\_\_

Name of Person Responsible for Payment (e.g. mother, father or guardian, not insurance): \_\_\_\_\_

Are individuals other than parents authorized to bring child in for visits? List below:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## EMERGENCY CONTACT (Other than parents)

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## **AUTHORIZATION FOR PAYMENT/RELEASE OF MEDICAL INFORMATION**

I authorize treatment of the patient above. I understand that all co pays and deductibles are to be paid at the time of service. I hereby assign to South Bascom Pediatrics, Inc. all payments for which I am entitled for medical and surgical expenses related to services rendered by them and direct that payments for such services be made directly to them. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by my policy. I understand that if the information I have provided to South Bascom Pediatrics, Inc. is not sufficient to bill my insurance or if the patient's services are not paid by my insurance within the contract limits, I will be responsible for the outstanding balance, if any. I will assist in the collection of my insurance benefit should there be any delay in payment. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection, including attorney fees. I authorize the release of such information (including a copy of this form) as may be required by my insurance company and/or referring doctor and/or any doctor or practitioner to whom the patient is referred. I have received a copy of office payment policies.

I have also received a "Notice of Privacy Policy" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Our physicians are licensed by the Medical Board of California and we are required to notify patients of the following:  
**NOTICE TO CONSUMERS:** Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, [www.mbc.ca.gov](http://www.mbc.ca.gov).

Signature of Parent or Legal Guardian Responsible for Account

Date

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