NOE VALLEY PEDIATRICS

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____ Sex: ☐ F ☐ M

Preferred Pronouns: ☐ She/her ☐ He/ him ☐ They/them

Siblings & Birthdays: _____

Preferred Primary Contact: ☐ Parent 1 ☐ Parent 2 ☐ Either Parent

Marital Status: ☐ *Single* ☐ *Married* ☐ *Domestic Partners* ☐ *Separated* ☐ *Divorced*

Parent 1: _____ ☐ Female ☐ Male
First Last Date of Birth

Preferred Pronouns: ☐ She/her ☐ He/ him ☐ They/them

Address: _____
Street City Zip code

Cell: _____ Alternate Number: _____ Occupation: _____
Occupation Employer

Email Address _____
Please Print Clearly

Parent 2: _____ ☐ Female ☐ Male
First Last Date of Birth

Preferred Pronouns: ☐ She/her ☐ He/ him ☐ They/them

Address: _____
Street City Zip code

Cell: _____ Alternate Number: _____ Occupation: _____
Occupation Employer

Email Address _____
Please Print Clearly

Emergency Contact: _____ Phone #: _____

HEALTHCARE INFORMATION

Preferred Pharmacy: _____

Preferred Provider (office use only): _____

INSURANCE INFORMATION *(please provide a scanned copy of the front and back of your insurance card)*

Our office will bill those insurance carriers that we are contracted with. You are responsible the deductible, share of cost, and co-payment at the time of service and any costs not a benefit of your plan. Failure to pay your copayment at the time of service will result in an administrative fee. If you do not have insurance, payment will be requested at the time of your visit.

I authorize payment of medical payments to be made directly to the provider for the services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance carrier.

APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE WILL INCUR A $50.00 "NO SHOW" FEE

Signature: _____ **DATE:** _____