ABC PEDIATRICS
ADOLESCENTS · BABIES · CHILDREN
702 WAKE AVE
EL CENTRO, CA 92243
760-352-7216

PATIENT NAME/ Nombre: ______________________________ **DOB**/ Fecha De Nacimiento: ______________

SEX: **M / F**

HOME ADDRESS/Direccion De Residencia ______________________________

CITY/ Ciudad: __________________ **STATE**/ Estado ________ **ZIP CODE**/ Codigo Postal ______________

HOME PHONE #/ Telefono: (_______) ________-__________ **CELL PHONE**/ Celular: (_______) ________-__________

(IF DIFFERENT FROM ABOVE/Si Es Diferente A La Direccion De Residencia**)**

MAILING ADDRESS / Direccion De Correspondencia ______________________________

CITY/ Ciudad: __________________ **STATE**/ Estado________ **ZIP CODE**/ Codigo Postal ______________

FATHER'S NAME/ Nombre Del Padre: ______________________ **DOB**/Fecha De Nacimineto ______________

EMPLOYER NAME/ Nombre Del Empleador: ______________________ **PHONE #**/ Telefono (_______) ______________

MOTHER'S NAME/ Nombre De Mama ______________________ **DOB**/ Fecha De Nacimiento: ______________

EMPLOYER NAME/ Nombre Del Empleador:______________________ **PHONE #**/ Telefono (_______) ______________

****EMERGENCY CONTACT**** **(who may we contact if we are unable to reach the parent?)**/ Contacto De Emergencia (En caso que no podamos contactar los padres): ______________________ **PHONE#**/ Telefono (_______) ______________

RELATIONSHIP WITH PATIENT/ Parentesco Con El Paciente: ______________________________

Insurance information /Aseguranza:

Primary Insurance:____________________**ID#**:________________ **GROUP #**: ______________

Name of Cardholder (Parent) ______________________________ **DOB**: ______________

Cardholder Relationship with patient:______________________________

Secondary Insurance:____________________**ID#**:________________ **GROUP #**: ______________

Name of Cardholder (Parent) ______________________________ **DOB**: ______________

Cardholder Relationship with patient: ______________________________

PATIENT'S SIBLINGS/Nombre de hermanos del paciente:

NAME/Nombre______________________________ **DOB**/Fecha de Nacimiento: ______________

NAME/Nombre______________________________ **DOB**/Fecha de Nacimiento: ______________

SIGNATURE/FIRMA: ______________________________**DATE/FECHA**: ______________

RELATIONSHIP WITH PATIENT/PARENTESCO CON EL PACIENTE: ______________________________

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I hereby authorize the following adults to bring my child:

(Patient name)______________________________ DOB: ________________, into the doctor's office for necessary testing and treatment in my absence. (Yo autorizo a las siguientes personas para traer a mi hijo a la oficina del doctor para tratamiento y pruebas necessarias en my ausencia).

Name	Relationship with Patient
____________________	____________________
____________________	____________________
____________________	____________________

SIGNATURE____ **Date:** ____________________
Relationship with Patient: ____

PATIENT PORTAL

Acknowledgement and Agreement:

I acknowledgement that I have read and fully understand this consent form and the procedures regarding Patient Portal. I understand the risks associated with online communications between my physicians and me, and consent to the conditions outlined herein. In addition, I agree to follow instructions set forth herein , including the polices and procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patient s via online communication. I agree to keep my password confidential and notify the office if my email address changes at any time. I understand and agree with the information that I have been provided.

Email: ____

PARENT/GUARDIAN SIGNATURE______________________________ **Date:** ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES- HIPPA.

I hereby acknowledge that I received a copy of the medical Practice Notice of Privacy Practices.

PARENT/GUARDIAN SIGNATURE______________________________ **Date:** ____________