Pediatrics West, P.C.
health care for the growing years

Welcome to Pediatrics *West*

Thank you for choosing our practice. All Information will be STRICTLY CONFIDENTIAL.

_____ _____ _____

Patient Legal Name (First, Middle, Last) | DOB (M/D/Y) | Today's Date

Race: (circle one)	**Ethnicity: (circle one)**	**Language: (circle one)**
❑ Asian ❑ Black/African American ❑ Caucasian ❑ Chinese ❑ Hispanic ❑ Japanese ❑ American Indian or Alaska Native ❑ Latino ❑ Multiracial ❑ Pacific Islander ❑ Other	❑ Hispanic ❑ Non Hispanic ❑ White ❑ Other **Sex (circle one)** ❑ Male ❑ Female	❑ English ❑ French German ❑ Hindi ❑ Mandarin ❑ Spanish ❑ Vietnamese ❑ Other

_____

Street Address

_____

City / State / Zip

_____

Mailing Address (if different from the street address)

_____ _____ _____

Home Phone: | Patient Cell (If 13+) | Email

_____

Who referred you to the office?

Mother/Guardian's Name: _____ _____
Relationship to Child:

_____ _____
Work/Cell Phone DOB (M/D/Y)

Father/Guardian's Name: _____ _____
Relationship to Child:

_____ _____
Work/Cell Phone DOB (M/D/Y)

Patient's Primary Care Doctor (as listed with Insurance company)

_____

PERSON RESPONSIBLE FOR BILL: (must be parent/guardian)

_____ _____ _____
Mother/Guardian (First, Middle, Last) SS# DOB (M/D/Y)

_____
Street Address **(If different from above)**

_____
City / State / Zip

_____
Insurance ID **#**

_____ _____
Insurance Group CoPay

_____ _____ _____
Father/Guardian (First, Middle, Last) SS# DOB (M/D/Y)

_____
Street Address **(If different from above)**

_____
City / State / Zip

_____
Insurance ID **#**

_____ _____
Insurance Group CoPay

Insurance Information: (patients are required to show insurance cards at all visits)

_____
Signature of Patient/Parent/Legal Guardian **Date**