Valle
Verde
Pediatrics

15525 Pomerado Road, Ste B1
Poway, CA 92064
tel: 858-487-8333 fax: 858-487-0856

PATIENT REGISTRATION

Patient DOB:_____

Patient first name: _____ Last Name:_____ SS#_____

Address: _____ City:_____ State:_____ Zip:_____

Primary Contact Phone Number: _____ Primary Name:_____

First Name of Father: _____ Last Name of Father:_____

Father DOB:_____ SS#:_____ DL#:_____

Father Employer:_____

First Name of Mother: _____ Last Name of Mother:_____

Mother DOB:_____ SS#:_____ DL#:_____

Mother Employer:_____

Insurance Information

#1	Primary Insurance Company Name	ID#	Group #
	Subscriber's Name	Relationship	Plan
#2	Secondary Insurance Company Name	ID#	Group #
	Subscriber's Name	Relationship	Plan

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT INFORMATION

I hereby authorize the release of any information required by my insurance company and I request that payments be made directly to: Valley Verde Pediatrics Medical Group, Inc.

Signed_____ Date:_____

Confidential Channel Communication Request

I consent to the use of the following confidential channels for the communication of information related to:_____ (child's name)

Please select all that apply:

[ ] Phone [ ] Ok to Leave Messages

[ ] Mail [ ] Email (address)_____

Signature:_____ Date:_____