SIMI PEDIATRIC PARTNERS

Stewart Brooks, MD Lauren Tashman, MD

Phone: (805) 527-9400 Fax: (805) 582-1344

Patient's name:_____ Birthdate:_____ Age:_____Sex:____

Family Members (include parents and siblings)

First Name	Last Name	Date of Birth	Age	Sex

Address_____ City_____ Zip_____

Phone Numbers **(please circle cell, home, or work and note relation to patient next to contact number)**

Primary: (Cell, Home, Work)	Alternate 1: (Cell, Home, Work)	email address:

Marital Status of parents: Married Single Divorced

Insurance Policy Holder Address (if different from above)_____

Father's Employer_____ Phone #_____

Mother's Employer_____Phone #_____

Last 4 digits SS# Father_____ Father's Driver's License #_____

Last 4 digits SS# Mother_____ Mother's Driver's License #_____

Emergency Contact_____ Phone#_____ Relationship_____

Who referred you to this office?_____

TREATMENT AUTHORIZATION

I do hereby authorize the physicians of Simi Pediatric Partners to administer medical treatment to my child(ren) in my absence. I agree to assume all of the financial responsibility if I have no insurance, and all of the responsibility required by my insurance company if I do have insurance.

Parent's Signature _____ Date _____

INFORMATION AUTHORIZATION

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment.

Parent's Signature _____ Date_____