SOUTH EAST BAY PEDIATRIC MEDICAL GROUP, INC.

FELLOWS OF AMERICAN ACADEMY OF PEDIATRICS • INFANTS • CHILDREN • TEENAGERS
2191 MOWRY AVE., SUITE 600-C • FREMONT, CALIFORNIA 94538 • PHONE 792-4373

PATIENT INFORMATION

OFFICE ACCT. NO ______________________

HEALTH PLAN ELIGIBILITY CERTIFICATION:

I, ______________________ (subscriber of ins), understand that my dependent child is eligible for benefits under the terms of coverage from the ______________________ (name of ins. plan) health plan as of ______________________ (effective date), through my ______________________ (own/spouse/parents) employment at ______________________ (name of employer) and that I have selected the South East Bay Pediatrics Medical Group, Inc. from whom to receive medical services. I am aware that if the above is not true or if my insurance does not pay I (or the person financially responsible for me) am responsible for all charges related to the services provided.

Signature______________________ Date______________________

PATIENT'S NAME ______________________ DATE OF BIRTH ____________ AGE ________ SEX ______

PARENT RESPONSIBLE FOR MEDICAL BILLS ______________________ **HOME PHONE** ____________ **MESSAGE PHONE** ____________

HOME / MAILING ADDRESS ______________________
Street No. Street City Zip Code

______________________ Mom Cell Phone ______________________ Dad Cell Phone

FATHER OR (GUARDIAN) ______________________ SOC. SEC. # ____________ DRIVER'S LIC. # ____________ BIRTH DATE ____________

RELATION TO CHILD ______________________

OCCUPATION ______________________ EMPLOYED BY ______________________ WORK PHONE ____________

MOTHER OR (GUARDIAN) ______________________ SOC. SEC. # ____________ DRIVER'S LIC. # ____________ BIRTH DATE ____________

RELATION TO CHILD ______________________

OCCUPATION ______________________ EMPLOYED BY ______________________ WORK PHONE ____________

PRIMARY INSURANCE COMPANY: ______________________

ID # ____________ GROUP # ____________ PHONE # OF INSURANCE COMPANY ____________

ADDRESS OF INSURANCE COMPANY: ______________________
CITY STATE ZIP

INSURED PERSON (IF DIFFERENT FROM ABOVE) ______________________

S.S. # ____________ DOB ________ EMPLOYER ____________ WORK PHONE ____________ RELATION TO CHILD ____________

SECONDARY INSURANCE COMPANY: ______________________

ID # ____________ GROUP # ____________ PHONE # OF INSURANCE COMPANY ____________

ADDRESS OF INSURANCE COMPANY: ______________________
CITY STATE ZIP

INSURED PERSON (IF DIFFERENT FROM ABOVE) ______________________

S.S. # ____________ DOB ________ EMPLOYER ____________ WORK PHONE ____________ RELATION TO CHILD ____________