MODESTO PEDIATRICS (2018)

3109 Coffee Road, Suite A - Modesto, CA 95355 - Phone (209)522-0001 - Fax (209)549-7077

18 Years of Age and Over

PRIMARY PHYSICIAN: *(Circle One)* **Dena Lenser, M.D.** **Ann Marie Truscello, M.D.**

PATIENT INFORMATION:

Last Name: ________________________ First Name: _______________________ MI: _____ Date of Birth: ________________ Sex: __________

Address: ____ City/State/Zip: ____

Home Phone: ___________________________ Cell Phone: ______________________________ Work Phone: _____________________________

SS#: ________________________ Driver's Lic.#/State Issued: ____________________________ Employer: _______________________________

e-mail: ____

INSURANCE INFORMATION:

Primary Insurance Company: ____________________________ ID#: ________________________ Subscriber's Name: _______________________

Secondary Insurance Company: __________________________ ID#: ________________________ Subscriber's Name: _______________________

EMERGENCY CONTACTS:

Name: ____ Relationship: ____

Main Phone: ____ Alternative Phone: ____

Name: ____ Relationship: ____

Main Phone: ____ Alternative Phone: ____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION:

INITIAL: _______________

I authorize Modesto Pediatrics, or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. Modesto Pediatrics has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care.

ACKNOWLEDGEMENT OF RECEIPT OF CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:

INITIAL: _______________

I acknowledge that I have received the Consent to Use and Disclose Health Information, which explains how my health information will be handled in various situation.

*****ATTENTION*****

Though you may still be covered under your parent's insurance, you, as an adult, are solely financially responsible for any and all payments: i.e., co-pay, coinsurance or deductible that your insurance deems as your responsibility.

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

PATIENT SIGNATURE: ____ **DATE:** _____________________________________

DATE: ____________________ **PATIENT INITIALS INDICATE NO CHANGE TO ABOVE INFORMATION:** __________________

DATE: ____________________ **PATIENT INITIALS INDICATE NO CHANGE TO ABOVE INFORMATION:** __________________