MODESTO PEDIATRICS (2018)

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

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

PATIENT INFORMATION:

Last Name: ________________________ First Name: _______________________ Date of Birth: _________________ Sex: _________

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Last Name: ________________________ First Name: _______________________ Date of Birth: _________________ Sex: _________

Last Name: ________________________ First Name: _______________________ Date of Birth: _________________ Sex: _________

IF DIVORCED/SEPARATED – CHILD RESIDES WITH: ____

IF DIVORCED/SEPARATED – MAIL STATEMENTS TO: ____

PARENT/GUARDIAN INFORMATION *(Please list both parties if applicable):*

Last Name: _____________________ First Name: ___________________ Date of Birth: __________ Relationship: ________________

Address: ____ City/State/Zip: ___________________________________

Home Phone: ________________________ Cell Phone: ____________________________ Work Phone: _________________________

SS#: ______________________ Driver's Lic.#/State Issued: ___________________________ Employer: _________________________

e-mail Address: ____

Last Name: _____________________ First Name: ___________________ Date of Birth: __________ Relationship: ________________

Address: ____ City/State/Zip: ___________________________________

Home Phone: ________________________ Cell Phone: ____________________________ Work Phone: _________________________

SS#: ______________________ Driver's Lic.#/State Issued: ___________________________ Employer: _________________________

e-mail Address: ____

INSURANCE INFORMATION:

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

Secondary Insurance Company: _____________________ ID#: __________________ Subscriber's Name: ________________________

EMERGENCY CONTACT *(Other than Parent):*

Name: ____ Relationship: __________________________________

Home Phone: _________________________________ Alternative Phone: ____________________________________

I do hereby authorize and consent to all medical treatment deemed necessary to treat the aforementioned patient. In addition, I authorize release of medical records and payment benefits for services rendered by the physician.

PARENT/GUARDIAN SIGNATURE: ____ **Date:** _______________________________

DATE: ______________ **PARENT/GUARDIAN INITIALS INDICATE NO CHANGE TO ABOVE INFORMATION** ____________

DATE: ______________ **PARENT/GUARDIAN INITIALS INDICATE NO CHANGE TO ABOVE INFORMATION** ____________