

Huntington Plaza Pediatric Group
800 S. Fairmount Ave. Suite 110
Pasadena, CA 91105
(626) 795 7051
HuntingtonPlazaPediatrics.com

Date: _____

Patient's Name: _____ DOB: _____ Sex: _____

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

Parent/Guardian: _____ DOB: _____ SS# _____

Occupation: _____ Work # _____ Cell # _____

Email Address: _____

Parent/Guardian: _____ DOB: _____ SS# _____

Occupation: _____ Work # _____ Cell # _____

Email Address: _____

Siblings

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Emergency Contact: _____ Relation: _____ Phone # _____

(If parent/guardian cannot be contacted)

Insurance Company: _____

Primary Subscriber: _____ DOB: _____

Subscriber # _____ Group # _____

It is the patient's responsibility to notify us of any insurance changes. Patients will be financially liable for any incurred charges not covered by their insurance.

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Patient History

Hospital Born at: _____

Birth Weight: _____ Birth Length: _____ Type of Delivery: _____

Problems: _____
(jaundice, prematurity, breach, birth defects etc).

Is your child adopted? If yes, please explain: Yes / No

Who can we thank for referring you to us? _____

Patient History

Family History

Allergies: No / Yes
Asthma: No / Yes
Diabetes: No / Yes
Seizures: No / Yes
Heart Disease: No / Yes
High Blood Pressure: No / Yes
High Cholesterol: No / Yes
Cancer: No / Yes

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Diabetes: No / Yes
Seizures: No / Yes
Heart Disease: No / Yes
High Blood Pressure: No / Yes
High Cholesterol: No / Yes
Cancer: No / Yes

Other: _____

Other: _____

Does patient take any medication? If yes, please explain:

Does patient have any allergies? (medication, foods, insects, etc.)

Please list any other important health information:

(injuries, illnesses, major operations, developmental delays, etc.)

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Cancellation Policy

Your appointment time is important to you, your doctor and to others who are in need of medical care. We charge for missed appointments and our requested cancellation policy is a 24 hour notice for all types of visits. A **\$50.00 fee** will be assessed per child for any missed or cancelled appointments without appropriate notice. Your cancellation must be made during regular office hours. You will be personally responsible for this charge. This charge will not be billed to, nor paid for, by your insurance company. As always, emergencies and unforeseen circumstances are taken into consideration.

Parent/Guardian Signature: _____ Date: _____

Financial Statement

Patients with managed care insurance (HMO, PPO, POS): Insurance cards must be presented at each office visit in order for us to bill your insurance. If you do not have proof of insurance, you may pay for services rendered at the time of service.

I authorize my children to receive health services with the understanding that if our insurance or managed care company determines that their care is a non-covered service I will be billed and held financially responsible for services rendered. Co-pays and co-insurance amounts are due at time of service. A billing fee will be applied to any balance not paid at time of service. If a collection agency is utilized to collect delinquent balances, the balance will be increased to include the agency's fee.

Primary Subscriber's Name: _____ DOB: _____

Subscriber # _____ Group # _____

Name of Insurance Company: _____

Signature of Subscriber/Guarantor: _____ Date: _____

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HIPAA Privacy Act

Please sign below that you have been offered an opportunity to review a copy of [our HIPAA Notice](#). You are entitled to a personal copy of the notice at any time to keep for your records. Thank you for your cooperation.

Patient Name: _____ DOB: _____

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Consent

I hereby authorize Huntington Plaza Pediatric Group to perform the necessary treatment advisable by the doctor for my child with or without me present.

Parent/Guardian Name: _____ Date: _____

Signature: _____

I hereby authorize the following person(s) to accompany my child(ren) to their appointment and to make any necessary decisions on my behalf.

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

Parent/Guardian Name: _____ Date: _____

Signature: _____