400 Taylor Boulevard, Suite 306 • Pleasant Hill, Ca 94523 • Phone: 925-691-9688 • Fax: 925-691-9820

Registration Information

PATIENT INFORMATION

Patient Name:			Date of Birth:	Gender (Circle One): M ☐ F ☐
Street:			Patient's Social Security Number:	
City:	State:	Zip:	Home Phone:	

PARENT INFORMATION (If foster care parent, please complete guardian section)

Parent's marital status: single married partnered separated divorced widowed			
Mother's Name:		Father's Name:	
Mother's DOB:	Mother's Social Security #:	Father's DOB:	Father's Social Security #:
Mother's address (if different than patient's):		Father's address (if different than patient's):	
Mother's employer:		Father's employer:	
Mother's phone (business):		Father's phone (business):	
Mother's cell phone:		Father's cell phone:	
Optional: Mother's email (will not be used to provide test results, only as a way to contact you):		Optional: Father's email (will not be used to provide test results, only as a way to contact you):	

PATIENT'S GUARDIAN (If foster care parent, please complete guardian section)

Name:	Social Security #:	Relationship to patient:
Address (if different from above):	Employer:	
City:	Home phone:	Work phone:

If foster care, list DFC's county and social worker:

PEDIATRICIAN OR OTHER PRIMARY CARE PROVIDER (PCP)

Last:	First:		Phone:
Street:	City:	State:	Zip code:

REFERRING PROVIDER (if different from PCP)

Last:	First:		Phone:
Street:	City:	State:	Zip code:

WHO CAN WE SPEAK WITH REGARDING YOUR CHILD? (e.g. grandmother, uncle, etc.)

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
☐ Not applicable		

FINANCIAL INFORMATION (Please bring all insurance cards and referral forms to every visit)

Primary insurance:	Effective Date:	Secondary Insurance:	Effective Date:
Insurance company name:		Insurance company name:	
Address to mail claim:		Address to mail claim:	
City:		City:	
Name of policy holder:		Name of policy holder:	
Policy holder's Social Security #:		Policy holder's Social Security number:	
Group #:	Policy #:	Group #:	Policy #:

I. FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by Diablo Valley Child Neurology, Inc physicians, unless the services are deemed “paid in full” as a result of a contractual agreement between Diablo Valley Child Neurology, Inc and my insurer. I understand that all charges not covered by my insurer, including co-pays, deductibles, diagnoses not covered under insurance terms and any charges for which I have failed to secure prior authorization, are due at the time of service. If I am not prepared to pay my co-pay or deductible at the time of service, my appointment may be rescheduled if medically appropriate. I understand that my insurance is billed as a courtesy and I am responsible for payment of balance in full if not paid by the insurance within 60 days. I understand that if Diablo Valley Child Neurology, Inc. does not participate with my insurance plan, I will be responsible for payment in full at the time services are rendered.

II. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to Diablo Valley Child Neurology Inc, the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Diablo Valley Child Neurology, Inc, for charges not covered by this assignment.

Signature of Responsible Party: _____

Printed Name: Date: