1900 Garden Rd. Suite 110, Monterey, CA 93940



Pre-Visit Questionnaire

Medical Record Number

Patient Name

Address:			DOB				
-duless.		City:	Zip Code:				
Sex: F M Birth	Weight: lbs	S OZ	Birth Length in				
Born Place (Hospital, Birth Center, ETC.)			Dr. who delivered:				
		RS INFORMATION					
ather's Name		DOB	SS#				
ather's Employer			Phone ()				
Business Address							
Email Address			Cell ()				
	MOTHE	RS INFORMATION					
Mother's Name		DOB	SS#				
Mother's Employer			Phone ()				
Business Address							
Email Address			Cell ()				
PATIENT SIBLINGS (list additional	children on back if neces	ssary)					
Name			DOB				
		•					
Name	DOB	Name	DOB				
Relative or friend we may contact in	an emergency:		Phone ()				
Address:							
Patient Insurance:							
	PROVIDE A COPY OF	INSURANCE CARD	; SEE BOTTOM OF PAGE				



Pediatric Group of Monterey

1900 Garden Rd. Suite 110, Monterey, CA 93940



CONSENT • AUTHORIZATION TO TREAT A MINOR

Medical Record Number
Patient Name

I), We), the undersigned parents of	diagnosis or treatment and er the general or special sup	hospital care which pervision of any
1		
2		
3		
4		
It is understood that this authorization is given in a hospital care being required, but is given to provide aforesaid agent(s) to give specific consent to any an which the aforementioned physician in the exercise It is also understood that every effort shall be made undersigned prior to rendering emergency treatments.	e authority and power in th nd all such diagnosis, treats e of his (her) best judgmen e by the above named agen	ne part of our ment, or hospital care t may deem advisable.
This authorization shall remain effective for one ye revoked in writing delivered to said agent(s).	ear from the date of executi	on or unless sooner
Date of Authorization:		
Parent(s) or Legal Guardian:	(Name)	(Signature)



FAMILY HISTORY FORM

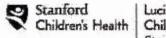


Patient Name:

DOB:

FAMILY HISTORY: Please check all that apply for each relative (v). M- indicates Maternal P- indicates Paternal

		JSE ,	/	//8		//20	/5/	/8/	X / 5	1 50	reto	essile	se bilit	25/	dation	//3/
Relationship Actival Att			hitis Asthr	a Defect	arcel do	Degression di	Sedie digies digital degital			Con the right door to the string to			& Disable	Weity less properties and a state of the sta		
Mother																
Father																
Sister																
Brother																
Daughter																
Son																
Maternal Aunt																
Maternal Uncle																
Paternal Aunt																
Paternal Uncle																
MGM																
MGF																省: 區-路川區: 圖 區
PGM																
PGF																
Please indicate other please indicate he Please indicate he How many siblings	re if the	patient re is no	was ad family l	opted history a	Yes	No										The second secon
If yes, please list n			_													
Has the patient ha If so, please explai		irgeries	or hosp	oitalizati	ons?			,								



Lucile Packard Children's Hospital Stanford

Lucile Packard Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

CONSENT • MYCHART PROXY ACCESS REQUEST

Medical Record Number

Patient Name

Addressograph or Label

MyChart Proxy Access Request Form- Request for Online Access to Medical Records

I hereby request Lucille Packard Children's Hospital Stanford/Stanford Children's Health provide access to health information in MyChart allowable by law, of the minor patient named below to the following proxy representative.

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's records by other means. To request a copy of your child's record, contact the medical records department.

 If your child is age 0-11: You will be granted full access to your child's MyChart record, a subset of complete medical records

MEDICAL RECORD ACCESS REQUEST

- If your child is age 12-17: You will be granted partial access to your child's MyChart record. (e.g. immunizations, messaging)
- Once your child reaches age 18, you will no longer have access to your child's MyChart record.

Please print legibly and complete all fields to ensure timely processing.

Patient Name: My relationship Are you the to patient: legal custodian*? □ Parent Last First Other ☐ Yes MRN: □No. Date of Birth: *Legal documents may be required, such as a birth certificate, guardianship papers, adoption documents, etc. REQUESTOR INFORMATION (Parent/Legal Guardian) Your Name: First Street Address: City: State: Zip Code: _____ Phone: Date of Birth: Date: Your Signature: FACILITY USE ONLY Patient Relationship Verified By: Date Received: Phone Number Name Proxy Access Approved: □Yes □No Letter Sent: DYes DNo Date Sent: Proxy MRN: ☐Form FAXED to HIMS for processing

Rev (05/14)