Silicon Valley Pediatricians
2505 Samaritan Dr., Suite 607
San Jose, CA 95124
Phone: 408-356-9900
Fax: 408-356-9939

Last Name_________________________________ First Name ________________________ Middle_______________________

Maiden Name______________________ Date of Birth_____________________ Sex __________ SS______________________

Street Address ___________________________________ City____________________ State________ Zip________________

Primary Phone #_________________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? ________

Secondary Phone #______________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? ________

Email Address____

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email ☐ MyChart

May we mail normal result letters and appointment reminders to you? ☐ Yes ☐ No

Preferred Language_______________________________________ Do you need an interpreter? ☐ Yes ☐ No

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Other ☐ Decline to disclose

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Caucasian
☐ Other ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Disclose

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Widowed

Significant Other Last Name_____________________________ First Name _____________________ Sex_____ DOB _________

Primary Phone # ________________________________ Secondary Phone # ____

Primary Care Provider Last Name______________________________ First Name______________________________________

Street___________________________ City________________ State_______ Phone_________________ Fax_______________

Referring Provider Last Name_________________________________ First Name ______________________________________

Street____________________________ City_______________ State________ Phone________________ Fax_______________

Preferred Pharmacy Name ______________________________________ Phone #_____________________________________

Street Address ______________________________ City________________ State_______ Zip_____________________________

Employer Name_______________________________________ Occupation____

Street Address______________________________ City_________________ State____________ Phone___________________

Emergency Contact 1 Last Name_________________________________ First Name____________________________________

Street Address_______________________________ City _________________ State_________ Zip _______________________

Primary Phone #_______________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Secondary Phone #_____________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Language ____ Does this contact require an interpreter? ______________

Relationship to you ____

Emergency Contact 2 Last Name_________________________________ First Name____________________________________

Street Address____________________________ City ___________________ State_________ Zip ________________________

Primary Phone #_______________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Secondary Phone #_____________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Language ____ Does this contact require an interpreter? ____________

Relationship to you____

Guarantor Information

Last Name_________________________________ First Name _________________________ Middle______________________

Date of Birth__________________ Sex __________ SS______________________ Phone #______________________________

Street Address ____________________________________ City____________________ State________ Zip_________________

Employer Name____ Occupation ______________________________________

Street Address ______________________________ City________________ State______ Phone #__________________________

Health Coverage Details

1. **Primary Coverage** _____________________________________ Auth Phone #_________________________________

Claim Address ____________________________________ City____________________ State________ Zip_________________

Name on Card: ____

Member relationship to the subscriber: _________________ Member ID #:___________________ Effective Date: __________

Subscriber's Last Name____________________________ First Name ______________________ Sex_____ DOB_____________

Street Address ____________________________________ City____________________ State________ Zip_________________

Subscriber ID #:___________________ Group #:_______________________ Group Name: ____________________________

2. **Secondary Coverage** _____________________________________ Auth Phone #_________________________________

Claim Address ____________________________________ City____________________ State________ Zip_________________

Name on Card: ____

Member relationship to the subscriber: _________________ Member ID #:___________________ Effective Date: __________

Subscriber's Last Name____________________________ First Name ______________________ Sex_____ DOB_____________

Street Address ____________________________________ City____________________ State________ Zip_________________

Subscriber ID #:___________________ Group #:_______________________ Group Name: ____________________________

Printed Name: ____

Signature: ____ Date:_____________________