COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.
3833 Worsham Ave., Suite 301 • Long Beach, CA 90808

PATIENT CHART INFORMATION

PLEASE FILL IN COMPLETELY

Patient Name _____ Birthdate _____/_____/_____ ☐ M ☐ F Born at_____Hospital

Patient Address _____ Daytime Phone (_____)_____
No. Street City State Zip

Email _____

BILLING

Parent/Guardian #1_____ Birthdate _____/_____/_____ Relationship_____

Address _____ Phone (_____) _____
No. Street City State Zip

Employed By _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian #2_____ Birthdate _____/_____/_____ Relationship_____

Address _____ Phone (_____) _____
No. Street City State Zip

Employed By _____ Work (_____) _____

Cell (_____) _____

Other Children: _____ B.D. _____/_____/_____ _____ B.D. _____/_____/_____

_____ B.D. _____/_____/_____ _____ B.D. _____/_____/_____

Who Referred You to Our Office? _____ Previous Doctor_____

Emergency Contact_____Relationship_____Phone (_____) _____

INSURANCE

Insured's Name _____ ID #_____ B.D. _____/_____/_____ Group #_____

Insurance Company _____ Address_____

2nd - Insured's Name_____ ID #_____ B.D. _____/_____/_____ Group #_____

Insurance Company _____ Address_____

FINANCIAL AGREEMENT *(Read before signing)*

I understand that fees are payable when service is rendered unless Columbia Pediatric's physicians are contracted with my insurance company and my insurance company will pay all fees at 100%. I understand that I am responsible for all non-covered services, co-insurance fees and co-payments.

I understand that for any reason it is necessary to carry a balance on my account, interest will be charged on any balance over ninety (90) days.

I understand that if my account is turned over to a collection agency, my child/children will no longer be treated by the physicians at Columbia Pediatrics Medical Group, Inc.

I have read and understand Columbia Pediatric's "Notice of Privacy Practices" regarding the uses and disclosures of my child's health information.

Signature _____

Date_____/_____/_____ Signature_____ Relationship to Patient_____