



ABUNTO-TOLENTINO PEDIATRICS, INC.
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Patient Information

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		
Male / Female:	DOB:	Age: SS #:
Name of the medical insurance:		
Whom may we thank for referring you:		
In case of emergency who should be notified:		

Father's Information **Guardian's Information** (please check one)

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		Mobile Phone:
DOB:	SS #:	
Company Name:		Phone:
Work Address:		
Is your child covered under your insurance? Y or N		
Name of the medical insurance:		

Mother's Information **Guardian's Information** (please check one)

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		Mobile Phone:
DOB:	SS #:	
Company Name:		Phone:
Work Address:		
Is your child covered under your insurance? Y or N		
Name of the medical insurance:		

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ (name of the insurance company) and assigned directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party Signature: _____ Date: _____
Relationship: _____

Privacy Practices Acknowledgement

I have been provided an opportunity to review the Notice of Privacy Practices.

Parent/Guardian signature: _____

Relationship to patient: _____