Pacific Coast Pediatrics
260 San Jose Street, Salinas CA 93901
831-757-8124

Patient Information

Patient Name:_____ Birthday: ___ / ___ / ___ Sex:_____

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Person responsible for charges: _____**Patient's relationship to this person:**_____
(mother, father or guardian)

Billing:_____
Address City State Zip Code

Home PH#: (_____) _____CELL#: (_____) _____

Primary Language: ☐ English ☐ Spanish ☐ Decline/prefer not to say ☐ Other: _____

Race: ☐ White ☐ African Amer. ☐ Asian ☐ Multi-racial ☐ Decline/prefer not to say

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline/prefer not to say

- **Preferred pharmacy where you would like prescriptions sent:** _____

FATHER
Name:_____
Birthdate:____ / ____ / ____
Employer Name:_____
Work Address:_____
Cell Phone: (_____) _____
Email Address:_____

MOTHER
Name: _____
Birthdate: ____ / ____ / ____
Employer Name: _____
Work Address: _____
Cell Phone: (_____) _____
Email Address: _____

PRIMARY INSURANCE
Insurance Name:_____
Subscriber:_____
ID#:_____
Insurance Address:_____
_____

SECONDARY INSURANCE
Insurance Name: _____
Subscriber:_____
ID#:_____
Insurance Address:_____
_____

Patient(s) live with _____ **Relationship, if other than parent:** _____
(Grandparent, Guardian etc.)

EMERGENCY CONTACT INFORMATION - In an Emergency, please contact (other than above) _____

Relationship _____ Phone (____) _____

Financial Policy/Agreement
We are contracted with many insurance carriers and are pleased to bill them directly for you. Once your primary insurance has processed your claim, we will then bill your secondary insurance with a copy of your explanation of benefits. If a copayment or deductible is part of your plan, we require that your portion is paid at the time of service.
Co-payments: *Are* due at the time of service. A $10 processing fee will be charged in addition to your co-payment if the co-payment is not paid at the time of service or by the end of our business day.
Private Pay Patients: If you have no medical insurance, payment for services is to be paid at the time of the visit, unless arrangements have been made with our financial department.
By signing, I hereby authorize the release of any medical information to insurance carriers needed to process a claim and request payment be made directly to **Pediatric & Adolescent Medical Associates of the Pacific Coast Inc.** for medical services rendered to my child. I understand that I am financially responsible for all charges not covered by my insurance, and that I must pay my portion within 30 days after my insurance has processed my claim.
Returned Checks: There is a $25 fee for any checks returned by the bank.

_____ _____ **Date:** ____ / ____ / ____
Name of Parent or legal Guardian **Signature**