

**MONTEREY PENINSULA PEDIATRIC MEDICAL GROUP**  
**PATIENT BILLING & INSURANCE INFORMATION**

**PERSON RESPONSIBLE FOR CHARGES:** \_\_\_\_\_  
**PATIENT NAME:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
**BILLING ADDRESS:** \_\_\_\_\_  
**CITY/STATE/ZIP:** \_\_\_\_\_  
**HOME PH#:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **PATIENT BIRTH DATE:** \_\_\_\_\_

**FATHER**

**MOTHER**

<b>NAME:</b> _____	_____
<b>SSN:</b> _____	_____
<b>BIRTHDATE:</b> _____	_____
<b>DRIVER'S LIC. #:</b> _____	_____
<b>EMPLOYER NAME:</b> _____	_____
<b>WORK PHONE:</b> _____	_____
<b>CELL PHONE:</b> _____	_____
<b>EMAIL ADDRESS:</b> _____	_____
<b>INSURANCE NAME:</b> _____	_____

**OTHER CHILDREN IN FAMILY:**

<b>NAME:</b> _____	<b>SEX:</b> _____	<b>BIRTHDATE:</b> _____	<b>SSN:</b> _____
<b>NAME:</b> _____	<b>SEX:</b> _____	<b>BIRTHDATE:</b> _____	<b>SSN:</b> _____
<b>NAME:</b> _____	<b>SEX:</b> _____	<b>BIRTHDATE:</b> _____	<b>SSN:</b> _____

**PRESENT INSURANCE CARD TO RECEPTIONIST FOR COPYING  
CONSENT FOR TREATMENT**

I grant to the physicians of Monterey Peninsula Pediatric Medical Group the authority to administer treatments and perform such procedures as may be deemed necessary for the above named patient(s).

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_  
*Relationship to patient(s):* \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS**

I hereby assign my insurance benefits to be paid directly to the physicians of the Monterey Peninsula Pediatric Medical Group. I am financially responsible for noncovered services. I also authorize the physician to release any information required to process my insurance claims.  
A photocopy of this signed authorization shall be considered as effective and valid as the original.

*Signature of Insured:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**H.I.P.A.A. NOTIFICATION**

I acknowledge receipt of M.P.P.M.G.'s notice of Privacy Practice and Patients' Rights effective 4/14/03

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_  
*Relationship to patient(s):* \_\_\_\_\_