

WESTONE PEDIATRICS

Dr. Todd Parrilla

Dr. Dena Ross

Dr. Jeniffer Campo

PERSONAL DATA SHEET

CHILDS NAME _____

MALE

FEMALE

LIVES WITH: MOTHER FATHER BOTH OTHER

CHILD'S DATE OF BIRTH _____ **CHILD'S SOCIAL SECURITY #** _____

FATHER'S NAME _____ **MOTHER'S NAME** _____
ADDRESS _____ **ADDRESS** _____

HOME PHONE _____ **HOME PHONE** _____

WORK # _____ **WORK #** _____

CELL # _____ **CELL #** _____

EMPLOYER _____ **EMPLOYER** _____

SS# _____ **SS #** _____

DATE OF BIRTH _____ **DATE OF BIRTH** _____

HIPPA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI). PLEASE SELECT HOW YOU WOULD LIKE OUR OFFICE TO COMMUNICATE WITH YOU. SHOULD ANY INFORMATION CHANGE PLEASE LET US KNOW.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (please circle)

HOME TELEPHONE _____ **WRITTEN COMMUNICATIONS**

1 - OK TO LEAVE MESSAGE

1 - OK TO MAIL HOME

2 - LEAVE CALL BACK NUMBER ONLY

2 - OK TO MAIL TO WORK

WORK TELEPHONE _____ **CELL NUMBER** _____

1 - OK TO LEAVE MESSAGE

2 - LEAVE CALL BACK NUMBER

A REMINDER CALL WILL BE GIVEN FOR PHYSICALS ONLY, BASED ON YOUR ABOVE SELECTION.

*****PARENT OR GUARDIAN SIGNATURE** _____ **DATE** _____

PLEASE READ THE FOLLOWING STATEMENTS BEFORE SIGNING

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS AND I AUTHORIZE MEDICAL BENEFITS TO BE PAID DIRECTLY TO **WESTONE PEDIATRICS**. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF ALL UNPAID CLAIMS.

*****PARENT OF GUARDIAN SIGNATURE** _____

PLEASE BE REMINDED ALL COPAYS ARE DUE THE DAY OF SERVICE