PEDIATRIC MANAGEMENT GROUP
UNIVERSITY CHILDRENS MEDICAL GROUP

PATIENT:____ DATE OF BIRTH: __________________ AGE: ________

ADDRESS:______________________________ CITY:_________________________ STATE:_______ ZIP:__________

HOME PHONE:____________________ WORK PHONE: ___________________ CELL PHONE:_________________

PARENT/GAURDIAN NAME:_____________________________ RELATIONSHIP TO PATIENT:________________

ADDRESS:______________________________ CITY:_________________________ STATE:_______ ZIP:__________

HOME PHONE:____________________ WORK PHONE: ___________________ CELL PHONE:_________________

INSURANCE/MEDICAL GROUP NAME:_________________________________ INSURED:___________________

CLAIM ADDRESS: ______________________________ CITY:___________________ STATE:_____ ZIP:__________

TELEPHONE:____________________ POLICY/CERT#:_______________________ GROUP#:__________________

SECOND INSURANCE:____ INSURED:__________________________

CLAIM ADDRESS: ______________________________ CITY:___________________ STATE:_____ ZIP:__________

TELEPHONE:____________________ POLICY/CERT#:_______________________ GROUP#:__________________

MEDI-CAL #:____ ISSUE DATE:__________________________

CCS #:_________________________________ EFF. DATE: ___________________ COUNTY: _________________

LANGUAGE PREFERENCE: _______________________________________

ASSIGNMENT:

I authorize PMD/UCMG to furnish information concerning this illness to insurance carriers, and assign to the doctors benefits otherwise payable to me, but no to exceed my indebtedness to them. I understand that I am financially responsible for charges not covered by this assignment. A photocopy of this authorization shall be as valid as the original.

____ __________________________________
Parent/Guardian Date