PATIENT INFORMATION FORM

Child Neurology of SLO
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Diplomate, American Board of Psychiatry and Neurology
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Office: (805) 434-0960 Fax: (805) 434-0978

Date: ____________________

Patient

Child's Name
Last: ____________________
First: ____________________
Middle: ____________________
AKA/Nickname: ____________________
Phone Number: ____________________
Birthdate: ____________________
Gender: ☐ Male ☐ Female
Email: ____________________
Mailing Address
Street: ____________________
City: ____________________
Zip Code: ____________________
Pediatrician/ Family Doctor: ____________________
Primary Language: ____________________

Emergency Contact
Other Than Parent (Required)

Name: ____________________
Relationship to Patient: ____________________
Phone Number: ____________________

Translator

Translator Name: ____________________
Phone Number: ____________________

Insurance Information

Primary Insurance: ____________________
ID#: ____________________
Subscriber Name: ____________________
Birthdate: ____________________

Secondary Insurance: ____________________
ID#: ____________________
Subscriber Name: ____________________
Birthdate: ____________________

Please bring all insurance cards and parent's photo ID to each appointment.

Thank you!

Parent/Guardian

Name
Last: ____________________
First: ____________________
Middle: ____________________
Relationship to Child: ____________________
Lives with child: ☐ Yes ☐ No
Mailing Address
Street: ____________________
City: ____________________
Zip Code: ____________________
Home Number: ____________________
Cell Number: ____________________
Work Number: ____________________
Marital Status: ____________________
Birthdate: ____________________
SSN#: ____________________
Employer: ____________________
Occupation: ____________________
Employer Address
Street: ____________________
City: ____________________
Zip Code: ____________________

Second Parent/Guardian

Name
Last: ____________________
First: ____________________
Middle: ____________________
Relationship to Child: ____________________
Lives with child: ☐ Yes ☐ No
Mailing Address
Street: ____________________
City: ____________________
Zip Code: ____________________
Home Number: ____________________
Cell Number: ____________________
Work Number: ____________________
Marital Status: ____________________
Birthdate: ____________________
SSN#: ____________________
Employer: ____________________
Occupation: ____________________
Employer Address
Street: ____________________
City: ____________________
Zip Code: ____________________