POMONA PEDIATRICS, PC
NEW PATIENT INFORMATION FORM

Parent Information:

Parent name: First:	Last:	
Relationship: Mother Father Guardian		Marital Status:
Street Address:		Email address:
City, State, Zip:		
Date of Birth:	Home Phone #:	Cell #:
Employer:		SS#:
Stepparent Full Name (if applicable):		

Parent name: First:	Last:	
Relationship: Mother Father Guardian		Marital Status:
Street Address:		Email address:
City, State, Zip:		
Date of Birth:	Home Phone #:	Cell #:
Employer:		SS#:
Stepparent Full Name (if applicable):		

Child(ren) Information:

Full Name (first and last)	Date of Birth	Sex	Full Name (first and last)	Date of Birth	Sex
		M or F			M or F
		M or F			M or F
		M or F			M or F
		M or F			M or F

Emergency Contact Information:

Full Name:		
Street Address:		
City, State Zip:		
Relationship:	Home Phone #:	Cell #:

Insurance Information:

Primary Insurance Name:	
ID#:	Group #:
Name of Policy Holder:	

Secondary Insurance Name:	
ID#:	Group #:
Name of Policy Holder:	

Parent's Signature:_____ Date:_____

Please bring the New Patient Information, Signature Page, Insurance Cards, and a copy of your child(ren)'s immunization record with you to your next visit.

POMONA PEDIATRICS, PC
SIGNATURE FORM

Please read and check the following statements in acknowledgment that you have read and understand the Financial, Privacy, and Immunization Policies of Pomona Pediatrics. These documents can be found at www.pompeds.com, where you can print and retain a copy for your records. Please bring this page with you to your next appointment.

☐ I have read and understand the Pomona Pediatrics Financial Policy and agree to abide by the terms of the policy.

☐ I have read and understand the Pomona Pediatrics HIPAA Patient Privacy Policy.

☐ I have read and understand that the vision test administered by Pomona Pediatrics is elective and may not by covered in full by my insurance company. I am responsible for any charges that result from the administration of the test if done on my child(ren).

☐ I read and understand the Pomona Pediatrics Immunization Policy.

☐ I understand that, if my insurance requires a copay, it is due at the time of service, and there is a $20 billing fee in the event that I do not pay at the time of service.

☐ I understand that there is a $25 fee for missed appointments if not canceled 24 hours before the scheduled appointment.

Parent Signature_____ Date_____

Print Name_____

Please bring the New Patient Information, Signature Page, Insurance Cards, and a copy of your child(ren)'s immunization record with you to your next visit.