



**COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.**
2840 Long Beach Blvd., Suite 315
Long Beach, CA 90806

PATIENT CHART INFORMATION
PLEASE FILL IN COMPLETELY

Patient Name _____ Birthdate ____/____/____ M F Born at _____ Hospital _____
Patient Address _____ Phone (____) _____
No. Street City State Zip

BILLING

Responsible Party _____ Birthdate ____/____/____ Relationship _____
Patient Address _____ Phone (____) _____
No. Street City State Zip
Employed By _____ Work (____) _____
Social Security Number _____ Cell (____) _____

SPOUSE _____ Birthdate ____/____/____ Relationship _____
Employed By _____ Cell (____) _____
Social Security Number _____ Work (____) _____
Other Children: _____ B.D. ____/____/____ _____ B.D. ____/____/____
_____ B.D. ____/____/____ _____ B.D. ____/____/____

Who Referred You to Our Office? _____ Previous Doctor _____
Nearest Relative _____ Relationship _____ Phone (____) _____

INSURANCE

Insured's Name _____ SS # _____ B.D. ____/____/____ Group # _____
Insurance Company _____ Address _____
2nd - Insured's Name _____ SS # _____ B.D. ____/____/____ Group # _____
Insurance Company _____ Address _____

FINANCIAL AGREEMENT *(Read before signing)*

I understand that fees are payable when service is rendered unless Columbia Pediatric's physicians are contracted with my insurance company and my insurance company will pay all fees at 100%. I understand that I am responsible for all non-covered services, co-insurance fees and co-payments.
I understand that for any reason it is necessary to carry a balance on my account, interest will be charged on any balance over ninety (90) days.
I understand that if my account is turned over to a collection agency, my child/children will no longer be treated by the physicians at Columbia Pediatrics Medical Group, Inc.

I have read and understand Columbia Pediatric's "Notice of Privacy Practices" regarding the uses and disclosures of my child's health information.

Signature _____

Date ____/____/____ Signature _____ Relationship to Patient _____