Ejaz Ahmed, M.D., F.A.A.P.
Jill Berry, C.P.N.P.
Evbu Ogbeide, M.D.
Anna Robertson, D.O., F.A.A.P.
Monica Riccomini, F.N.P
John Asarian, MD., F.A.A.P

PCP: Dr. Ahmed/Jill Berry/Dr. Ogbeide/Dr. Robertson/Monica Riccomini/Dr. Asarian (circle)

Please List all Children:

1. Child's Name___________________________________ D.O.B.____________ Male / Female
2. Child's Name___________________________________ D.O.B.____________ Male / Female
3. Child's Name___________________________________ D.O.B.____________ Male / Female
4. Child's Name___________________________________ D.O.B.____________ Male / Female
5. Child's Name___________________________________ D.O.B.____________ Male / Female

Father/Guardian____Date of Birth_________________

Biological ☐ Step ☐ Adoption ☐ Guardian ☐ If Guardian, How Related? ________________________________

Address_____________________________________City______________________State______Zip________

Home Phone_____________________Cell Phone_____________________Work Phone_____________________

Employed By______________________________________Occupation__________________________________

Social Security Number___________________________Driver's License Number________________________

Responsible For Bill? (Please Circle) YES NO E-Mail Address______________________________________

Mother/Guardian____Date of Birth_________________

Biological ☐ Step ☐ Adoption ☐ Guardian ☐ If Guardian, How Related? ________________________________

Address_____________________________________City______________________State______Zip________

Home Phone_____________________Cell Phone_____________________Work Phone_____________________

Employed By______________________________________Occupation__________________________________

Social Security Number___________________________Driver's License Number________________________

Responsible For Bill? (Please Circle) YES NO E-Mail Address______________________________________

If parents are divorced or separated who has custody?________________________________

Are there any legal restrictions regarding medical treatment? Yes / No Explain:___________________________

Primary Insurance______________________Subscriber_______________ ID Number___________________________

Secondary Insurance____________________Subscriber_______________ ID Number___________________________

Who has authorization to bring child and consent to treatment in absence of parents/guardian?
Please list name(s):

1.____Relation_________________Phone_____________
2.____Relation________________ Phone_____________

ASSIGNMENT OF BENEFITS - CONSENT TO TREATMENT - RELEASE OF INFORMATION

I, the parent or guardian of the above named minor, authorize Chico Pediatric Medical Group, Inc. to perform all necessary and advisable medical procedures for diagnosis and treatment. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement, except in cases of emergency. I also understand that I have the right to refuse any proposed medical procedure or treatment.

I authorize Chico Pediatric Medical Group, Inc. to disclose patient's medical records to my insurance company.

I assign to and approve direct payment to Chico Pediatric Medical Group, Inc. of any insurance benefits otherwise payable for patient's treatment. This assignment will remain in effect until revoked by me in writing. However, I fully understand that I am financially responsible to Chico Pediatric Medical Group, Inc. for charges not covered by this assignment.

Signed__________________________________Relationship__________________________Date____________