SAN DIEGO PEDIATRICS

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Patient's First Name:	Age:	Sex:	DOB:
Patient's Last Name:	Home Phone Number:		Mobile Phone Number:
Home Street Address:	City/State:		Zip Code:

Primary Contact/Guardian Information

First Name:	Relation to Patient:	S.S.#:
Last Name:	DOB:	Primary Language:
Home Street Address:	City/State:	Zip code:

Home Phone Number:	Mobile Phone Number:	Work Phone Number:
Email Address:		Preferred Contact Method (please circle): Home Mobile Work Email

Secondary Contact/Guardian Information

First Name:	Relation to Patient:	S.S.#:
Last Name:	D.O.B:	Primary Language:
Home Street Address:	City/State:	Zip code:

Home Phone Number:	Mobile Phone Number:	Work Phone Number:
Email Address:		Preferred Contact Method (please circle): Home Mobile Work Email

Emergency Contact (other than parents)

Full Name:	Relation to Patient:	Contact Number:

Please list any additional people authorized to accompany the patient to appointments and consent to medical care

Full Name:	Relation to Patient:	Contact Number:
Full Name:	Relation to Patient:	Contact Number:

Authorization to pay benefits: I hereby authorize payment directly to Joel M. Snyder M.D. AMC for any procedures including surgical, medical, physicals, and immunizations. I understand that if I am not eligible under the terms of my health plan agreement, or if for any reason the insurance company does not pay, that I am liable for all services rendered. I also understand that I am liable for fees incurred for missed appointments.

Primary Insured: X _____.

Authorization for Medical Care: X _____.