FLATON ADDEPT CENTER
San Luis Obispo, California 93401

Patient Demographic/Insurance Form - (under 18)

Patient Name: _____ **DOB:**____/____/____
First Middle Last

Patient Information

Address: _____
Street Address City State Zip

Mailing Address (*if different from address above*):

_____
Street Address City State Zip

Gender: ▢ M / ▢ F

Sibling: _____ DOB: _____ Resides w/ Patient: ▢ Y / ▢ N

Sibling: _____ DOB: _____ Resides w/ Patient: ▢ Y / ▢ N

Sibling: _____ DOB: _____ Resides w/ Patient: ▢ Y / ▢ N

Patient Resides With: ▢ Father ▢ Mother ▢ Other (relationship) _____

School Child Attends:: _____ Grade: _____

#1 Parent/Guardian Information Name:_____

Address: _____
Street Address City State Zip

Mailing Address (*if different from address above*):

_____
Street Address City State Zip

▢ Cell Phone :_____ Text: ▢ Y / ▢ N ▢ Home Phone:_____

Email:_____

Preferred method of contact: ▢ Cell call ▢ Cell text ▢ Home call ▢ Email

#2 Parent/Guardian Information Name:_____

Address: _____
Address City State Zip

Mailing Address (*if different from address above*):

_____
Street Address City State Zip

▢ Cell Phone :_____ Text: ▢ Y / ▢ N ▢ Home Phone:_____

Email:_____

Preferred method of contact: ▢ Cell call ▢ Cell text ▢ Home call ▢ Email

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San Luis Obispo, California 93401

Patient Demographic/Insurance Form - (under 18)

Patient Name: _____ DOB:____/____/____
First Middle Last

Primary Care Pediatrician

Primary Care Pediatrician: _____

Office Phone Number:_____Fax Number: _____

Address: _____
Street Address City State Zip

Primary Insurance

Insured's Name:_____ ▢ Male ▢ Female

Relationship to Patient: ▢ Self ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other Insured's DOB: ____/____/_____

Member ID Number: _____Group Number: _____

Secondary Insurance

Insured's Name:_____ ▢ Male ▢ Female

Relationship to Patient: ▢ Self ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other Insured's DOB: _____/_____/_____

Member ID Number: _____ Group Number: _____

Emergency Contact:

Name: _____ DOB: ____/_____/_____

Relationship to Patient: ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other _____

Phone Number: _____Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Responsible Party for Financial Payment

Name:_____ DOB: _____

Relationship to Patient: ▢ Parent/Guardian ▢ Spouse ▢ Child ▢ Other _____

Phone Number: _____ Email:_____

Address: _____
Street Address City State Zip

Social Security # _____-_____-_____

Responsible party signature _____ Date: _____