

PLEASANT VALLEY PEDIATRIC MEDICAL GROUP

Infants Children Adolescents

2486 Ponderosa Dr. N., Suite D-211, Camarillo, CA 93010 805-484-2818

William Bocash, M.D., F.A.A.P.

Jon D'Andrea, M.D., F.A.A.P.

Lynn J. Galan, M.D., F.A.A.P.

Deborah Marlow-Mejia, M.D., F.A.A.P.

Robert Vasko, M.D., F.A.A.P.

Pediatric Registration Form

Patient Name:	Age:	Sex:	Birth date:

Home Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Email Address: _____

We cannot bill your insurance unless the following section is completed or you will be considered a cash paying patient and will be expected to pay at the time of service

Mother's First and Last Name:	Birth date:	Social Security #:
Drivers License #:	Occupation/Employer's Name:	
Work Phone #: ()	Cell phone #: ()	Cell Carrier:
Home address if different from children:		

Father's First and Last Name:	Birth date:	Social Security #:
Drivers License #:	Occupation/Employer's Name:	
Work Phone #: ()	Cell phone #: ()	Cell Carrier:
Home address if different from children:		

AUTHORIZATION FOR EMERGENCY TREATMENT:

I authorize the physicians of Pleasant Valley Pediatric Medical Group to treat my
Child(ren) _____ in case of emergency in the case that I cannot be
reached.

Parent/Guardian Signature: _____

Relative or close friend to be contacted in case of emergency: _____

Phone: (____) _____

PLEASE COMPLETE BACK SIDE!

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PVP REQUIRES YOU TO COMPLETE INSURANCE INFORMATION. COPY OF INSURANCE CARD DOES NOT ALWAYS CONTAIN ALL INFORMATION NECESSARY TO BILL. THANK YOU.

Primary Insurance: _____

Cert./ID # _____

Name of Policy Holder: _____

Group # _____

Employer's Name: _____

Effective Date of Coverage: _____

Social Security # _____

Date of Birth: _____

What are your benefits? Copay _____ Deductible _____ Percentage _____

Secondary Insurance: _____

Cert./ID # _____

Name of Policy Holder: _____

Group # _____

Employer's Name: _____

Effective Date of Coverage: _____

Social Security # _____

Date of Birth: _____

What are your benefits? Copay _____ Deductible _____ Percentage _____

I, _____, hereby certify that my dependants and I a eligible for
Name of Member/Patient

_____ benefits on or as of _____ through _____.
Insurance Company Name Effective Date Employer Group Name

Please be advised that you are responsible for knowing your benefits and keeping track of your maximum benefits.

Assignment of Benefits

I have chosen PLEASANT VALLEY PEDIATRIC MEDICAL GROUP to be my Medical Provider. I understand that if the above is not true, or if my plan does not pay for services rendered within 45 days, that I will be responsible for all the charges related to service provided to my child(ren). I agree that if it is determined that I am financially responsible, I will pay in full for all services rendered within 30 days of receiving the bill. I authorize payment of medical benefit to the above named physician/medical group or supplier for services rendered to the above named patients. Should I have no insurance coverage or proof of coverage, I will be expected to pay in full for services rendered at the time of service. I also acknowledge that during a physical, should I have questions or receive treatment for other than a physical: an additional charge will be added and billed to my insurance. PVP will only send statements and notices to the address/email address were the child(ren) reside.

Date

Signature of responsible party