



**ABUNTO-TOLENTINO PEDIATRICS, INC.**  
1001 Sneath Lane, Suite 104, San Bruno, CA 94066  
P (650) 873-45445 F(650) 873-4544

**Patient Information**

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		
Male / Female:	DOB:	Age: SS #:
Name of the medical insurance:		
Whom may we thank for referring you:		
In case of emergency who should be notified:		

**Father's Information**       **Guardian's Information**      (please check one)

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		Mobile Phone:
DOB:	SS #:	
Company Name:		Phone:
Work Address:		
Is your child covered under your insurance? Y or N		
Name of the medical insurance:		

**Mother's Information**       **Guardian's Information**      (please check one)

Last Name:	First Name:	MI
Address:	City:	State: Zip Code:
Home Phone:		Mobile Phone:
DOB:	SS #:	
Company Name:		Phone:
Work Address:		
Is your child covered under your insurance? Y or N		
Name of the medical insurance:		

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ (name of the insurance company) and assigned directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.  
Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**Privacy Practices Acknowledgement**

I have been provided an opportunity to review the Notice of Privacy Practices.

Parent/Guardian signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_