



The below is required information that we need in order to serve you better. Please complete the form in its entirety.

Primary Care Physician: Gillespie Bergdahl Fraley Kim Vazquez Mireles- Chavez Moreno
(Please Circle One)

I. Child's Information

Patient Name: _____ Sex: M or F Child's SSN _____

Date Of Birth _____ Child lives with: Parents Father Mother Other _____

Patient Name: _____ Sex: M or F Child's SSN _____

Date Of Birth _____ Child lives with: Parents Father Mother Other _____

Patient Name: _____ Sex: M or F Child's SSN _____

Date Of Birth _____ Child lives with: Parents Father Mother Other _____

Patient Name: _____ Sex: M or F Child's SSN _____

Date Of Birth _____ Child lives with: Parents Father Mother Other _____

II. Parent/Guardian Information (For Step-parent(s) information please complete section III of this form located on the reverse side).

Parents are: Married Single Divorced Widowed Domestic Partners (Please Circle One)

Parent Name _____ Parent Name _____

Gender - Male or Female Date of Birth _____ Gender - Male or Female Date of Birth _____

Address _____ Address _____

City/Zip _____ City/Zip _____

Home Phone _____ Cell Phone _____ Home Phone _____ Cell Phone _____

Employer _____ Employer _____

Work Phone _____ Ext. _____ Work Phone _____ Ext. _____

Drivers Lic.# _____ SSN _____ Drivers Lic # _____ SSN _____

Religion (Optional) _____ Religion (Optional) _____

III. Step-Parent Information

In compliance with HIPAA regulation, step-parents are unable to receive medical information about their step-children. Fresno Children's Medical Group requires a separate form to have on file that is written and signed by one biological parent stating information in relation to the health of the child can be released to the step-parent(s).

Step-Parent Name _____ Step-Parent Name _____
Gender - Male or Female Date of Birth _____ Gender - Male or Female Date of Birth _____
Address _____ Address _____
City/Zip _____ City/Zip _____
Home Phone _____ Cell Phone _____ Home Phone _____ Cell Phone _____
Employer _____ Employer _____
Work Phone _____ Ext. _____ Work Phone _____ Ext. _____
Drivers Lic.# _____ SSN _____ Drivers Lic # _____ SSN _____
Religion (Optional) _____ Religion (Optional) _____

IV. Do you have other children that are patients of this practice that have a different last name? Y or N

If "Yes" please list those children below:

Patient Name: _____ Date of Birth _____
Patient Name: _____ Date of Birth _____
Patient Name: _____ Date of Birth _____

V. NAME OF THE NEAREST LOCAL RELATIVE OR FRIEND TO CONTACT IN THE CASE OF EMERGENCY: Name _____ Relationship: _____

Address: _____ Phone: _____

VI. HIPAA- I hereby acknowledge that this medical practice's Notice of Privacy Practices was made available to me: Print Name: _____ Relationship to Patient: _____

Signed: _____ Date: _____

Below is for Staff Use Only:

Date Information updated: _____ Verified by: _____ Verified by: _____

Account Number: _____ Step-Parent Release on file: No _____ Yes _____ Dated _____