Stanford Children's Health

Altos Pediatrics

Patient Name: _____
Last First Middle Initial

Preferred name _____ Date of Birth _____ Sex _____

Street Address _____ City_____ State_____ Zip_____

Primary Phone #_____ ☐ Mobile ☐ Home ☐ Work May we leave a message? Y☐ N☐

Secondary Phone #_____ ☐ Mobile ☐ Home ☐ Work May we leave a message? Y☐ N☐

Preferred Language _____ Do you need an interpreter? Y☐ N ☐
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Other ☐ Decline to disclose

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Caucasian
☐ Other ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Disclose

Religion _____

Parent/Legal Guardian Information:

Name _____ Birthdate _____ Relationship _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____ Email _____
Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Name _____ Birthdate _____ Relationship _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____ Email _____
Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Who referred you? ☐ Insurance ☐ Friend/Family (please name): _____
☐ Obstetrician (please name): _____ ☐ Other: _____

Preferred Pharmacy Name _____ Phone #_____
Street Address _____ City_____ State_____ Zip_____

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Emergency Contact (other than parent)

Last Name_____ First Name_____

Primary Phone #_____ ☐ Mobile ☐ Home ☐ Work May we leave a message? _____

Language _____ Does this contact require an interpreter? _____

Relationship to patient_____

Guarantor Information

Last Name _____ First Name _____ Birthdate _____

Sex _____ Phone _____

Street Address _____ City_____ State_____ Zip_____

Employer Name_____ Occupation _____

Street Address _____ City_____ State_____ Phone #_____

Health Coverage Details (If insurance card not present)

1. Primary Coverage _____ Auth Phone #_____

Claim Address _____ City_____ State_____ Zip_____

Name on Card: _____

Member relationship to the subscriber: _____ Member ID #:_____ Effective Date: _____

Subscriber's Last Name_____ First Name _____ Sex____ DOB_____

Street Address _____ City_____ State_____ Zip_____

Subscriber ID #:_____ Group #:_____ Group Name: _____

2. Secondary Coverage _____ Auth Phone #_____

Claim Address _____ City_____ State_____ Zip_____

Name on Card: _____

Member relationship to the subscriber: _____ Member ID #:_____ Effective Date: _____

Subscriber's Last Name_____ First Name _____ Sex____ DOB_____

Street Address _____ City_____ State_____ Zip_____

Subscriber ID #:_____ Group #:_____ Group Name: _____

Printed Name: _____

Signature: _____ Date: _____