



Children's Medical Group

7101 Magnolia Avenue, Suite A • Riverside, CA 92504

Office (951) 682-9780 • Fax (951) 682-9787

www.iecmg.org

Patient Information Form

Child's Name: _____ M F Date of Birth: _____

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

Home Phone: (____) _____ Cell Phone: (____) _____ Child's SS#: _____

Person Responsible for Payment: _____

Name of other family members seen here: _____

Father's Name: _____ Driver's Lic#: _____

Social Security #: _____ Date of Birth: _____

Employed By: _____ Address: _____

Occupation: _____ Phone:(____) _____

Mother's Name: _____ Driver's Lic#: _____

Social Security #: _____ Date of Birth: _____

Employed By: _____ Address: _____

Occupation: _____ Phone:(____) _____

Legal Guardian _____ Relation to child: _____
(If Not the Parent)

Relative Whom We May Contact In Event Of Emergency (not living with child)

Name: _____ Phone: _____

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

Insurance Company: _____ Group # _____

ID or Certificate#: _____

Secondary Insurance (if applicable): _____

Insurance Authorization and Assignment

I hereby authorize Inland Empire Children's Medical Group physicians to furnish information to insurance carriers concerning illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I hereby consent to and authorize all treatment for my child considered necessary or advisable by the physician.

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES - INCLUDING CO-PAYS AND SHARE OF COSTS. THERE IS A \$26.00 CHARGE FOR ALL RETURNED CHECKS.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment; however, the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made with our patient representative.

Signature: _____ Date: _____



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