Stephen P. Kundell, MD and Laila Niazi, MD
Thousand Oaks Pediatrics

Father's Name_____Address_____
Street City State Zip
Father's Home Phone _____ Work Phone_____Cell Phone_____

Father's DOB_____Employer_____Occupation_____SS#_____

Employer Address_____Father's email_____

DL#:_____exp_____

Mother's Name _____Address_____
Street City State Zip
Mother's Home Phone _____ Work Phone_____Cell Phone_____

Mother's DOB_____Employer_____Occupation_____SS#_____

Employer Address_____Mother's email_____

DL#:_____exp:_____

Which parent is primary insured: _____
Preferred Contact Individual for appointments, lab results, and other communication: _____
Preferred contact type: □ email, □ cell phone, □ home phone,

PLEASE BRING YOUR CURRENT INSURANCE CARD OR A LEGIBLE COPY TO THE VISIT

CHILDREN **Please write names,birthdates, and cell phone if applicable**

1_____ 4. _____

2._____ 5. _____

3._____ 6. _____

Has any parent or child died? Yes_____ No_____ If yes, what cause? _____

Are any children adopted? Yes_____ No_____ If yes, at what age? _____

Previous or referring physician _____

Person to contact in emergency, if neither parent is available:

Name_____Relationship _____

Address _____

Phone_____

I wish to assign insurance payment to Drs. Kundell and Niazi. I understand that my insurance plan may require a review of records prior to reimbursement. I give my permission for said record release.

Signature_____**Date**_____