1401 Avocado Street, Suite 802
Newport Beach, CA 92660

INFORMED CONSENT

I hereby authorize the administration of: _____

for my child: _____

I have been informed my insurance carrier WILL NOT be billed for the above service and I am responsible for payment. I understand my insurance carrier either does not cover the above service or does not reimburse the medical group to cover the expense of the service.

If I choose to bill my carrier on my own and the insurance makes payment to Newport Children's Medical Group, I will only be refunded the amount insurance has paid. Newport Children's Medical Group does not accept the allowed amount or any contractual allowance that my insurance carrier determines.

_____ _____

PARENT NAME (PLEASE PRINT) DATE

_____

PARENT SIGNATURE

NEWP[illegible]T CHILDRENS MEDICAL [illegible]OUP

1401 Avocado St., Suite 802
Newport Beach, CA 92660
Tel.# (949) 644-0970

307 Placentia Ave., Suite 209
Newport Beach, CA 92663
Tel.# (949) 642-7332

17692 Beach Blvd., Suite 205
Huntington Bch, CA 92647
Tel# (714) 698-1648

PLEASE COMPLETE ENTIRE FORM: (PLEASE PRINT)

Date_____

Patient_____ Age_____ DOB_____Gender_____

Home Address_____

City_____ State_____ Zip_____Phone_____

SSN_____

Fathers Name_____ Mothers Name _____

Married / Single / Divorce / Widow Married / Single / Divorce / Widow

DOB_____ SSN_____ DOB_____ SSN_____

E-Mail_____ E-Mail_____

Work#_____Cell#_____ Work#_____Cell#_____

Emergency Contact:

Name_____ Relationship_____ Phone #_____

City_____ State_____

Insurance Info:

Company_____ **Subscribers Name**_____

DOB_____ **Subscribers ID#**_____ **Group #**_____

Please List Other Children:_____ DOB_____

_____ _____

_____ _____

_____ _____

Please List Authorized Individuals Who Can Give Medical Consent In Your Absence (Including Medical Office Services, Etc.)

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Payments for services are due at the time of service. A $10.00 fee will be charged if we have to bill you for your co-pay. Payments can be made by check, cash or by credit card. We only bill Insurance companies we are a provider of. It is necessary that you supply an insurance card at the time of visit. If you do not have one, payment will be made at the time of service and you will be supplied with a super bill so that you may bill your insurance company. **All charges incurred are the financial responsibility of the undersigned regardless if insurance coverage, child support and/or other outside agreements or arrangements.** A monthly finance charge of .83% may be added to unpaid balances after 30 days. (10%) Additional fees for After Hours, Walk-Ins, Weekends, etc., may be applicable and all fees are subject to change at any time without prior notification.

_____ _____ _____

Signature of Parent or Guardian Printed Name Date

Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

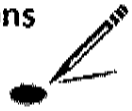
Review Of Systems Pediatric

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Has your child had any problems with or do you have concerns with any of the following?

Mark all that apply. If no symptoms, please mark "NONE."

General

fevers / chills / excessive sweating ◯
fatigue ◯
unexplained weight loss / gain ◯
NONE ◯

Eyes

eye discharge ◯
squinting or "crossed" eyes ◯
NONE ◯

Ears / Nose / Throat

frequent runny nose ◯
frequent ear infections / ear pain ◯
frequent sore throats ◯
frequent colds ◯
unusually loud voice / hard of hearing ◯
mouth breathing / snoring ◯
bad breath ◯
problems with teeth / gums ◯
nose bleeds ◯
NONE ◯

Respiratory

cough ◯
difficulty breathing ◯
wheezing ◯
NONE ◯

Gastrointestinal

nausea / vomiting ◯
constipation ◯
diarrhea ◯
abdominal pain ◯
blood in bowel movement ◯
NONE ◯

Cardiovascular

tires easily with exertion ◯
shortness of breath ◯
fainting ◯
NONE ◯

Genitourinary

pain with urination ◯
bedwetting ◯
discharge from penis or vagina ◯
NONE ◯

Muscular / Skeletal

muscle or joint pain ◯
NONE ◯

Allergy

hay fever / itchy eyes ◯
NONE ◯

Skin

rash(es) ◯
unusual mole(s) ◯
NONE ◯

Emotional

speech problem(s) ◯
problem(s) with sleep / nightmares ◯
bad temper / breath holding / jealousy ◯
depression ◯
nail biting / thumb sucking ◯
headaches ◯
anxiety / stress ◯
NONE ◯

Blood / Lymph

unexplained lump(s) ◯
easy bruising / bleeding ◯
NONE ◯