MICHAEL TAYMOR
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Palo Alto, CA 94301
(650)321-7722 (650) 326-7775 FAX

Patient Information / Informacion del Patiente

First Name	Last Name	DOB	Sex	Child Lives With
1.				□ Father □ Mother □ Both Parents □ Guardian
2.				
3.				

Ethnicity: □ American Indian □ African American □ Asian □Mex. Amer./Hispanic □Pacific Islander □ White □Other

Father's Name:	**Mother's Name:**
DOB: SSN#:	DOB: SSN#:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell #: Work #:	Cell #: Work #:
Employer:	Employer:
Father's Email	Mother's Email:

Primary Insurance:	**Secondary Insurance**:
Subscriber's Name	Subscriber's Name:
Co-Pay:	Co-Pay:
ID #	ID #
Group #	Group #

Preferred Pharmacy:	Pharmacy Address/Intersection:

Emergency Contact: (not living in the same household)	Phone:	Relationship to Patient:

_____ _____ _____

Signature (Parents/Guardian) **Date**: **Relationship to Patient**:

CONSENT

I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to Michael Taymor, M.D. I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize Dr. Taymor's Office and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Patient's Name:_____

Signature (Parents/Guardian) _____ **Date:** _____