Dr. Dafna Ahdoot MD, FAAP
Location: The Encino Town Center, 17200 Ventura Blvd Suite 212, Encino CA 91316
(P) 818-208-2626 (P) 855-DR-DAFNA (F) 818-208-3434

Welcome to Milk and Honey Pediatrics!

Please fill out this form to register your child/children as a new patient.

Child's Information:

First and Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Ethnicity: _____ Race: _____ Preferred Language: _____

Medical History:

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list: _____ Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Has your child had any surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please provide details: _____

Child's Information:

First and Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Ethnicity: _____ Race: _____ Preferred Language: _____

Medical History:

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list: _____ Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Has your child had any surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please provide details: _____

Physical Address: _____

Mailing Address: _____

(If different from physical address)

Preferred Pharmacy Information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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Parent/Guardian 1 Information:

First and Last Name: _____ Date of Birth (MM/DD/YYYY): _____
Sex: ☐ Male ☐ Female Relationship to Child: _____ Marital Status: _____
Cell Number: _____ Work Number: _____ Email Address: _____
Employer: _____ Occupation: _____
Physical address same as patient: ☐ Yes ☐ No
If not, please enter: _____ Mailing address same as patient: ☐ Yes ☐ No
If not, please enter: _____

Parent/Guardian 2 Information:

First and Last Name: _____ Date of Birth (MM/DD/YYYY): _____
Sex: ☐ Male ☐ Female Relationship to Child: _____ Marital Status: _____
Cell Number: _____ Work Number: _____ Email Address: _____
Employer: _____ Occupation: _____
Physical address same as patient: ☐ Yes ☐ No
If not, please enter: _____ Mailing address same as patient: ☐ Yes ☐ No
If not, please enter: _____

Emergency Contact Information (other than parent/guardian):

- First and Last Name: _____ Relationship to Child: _____
  Cell Phone Number: _____

Persons allowed to accompany minor during office visits:

- First and Last Name: _____ Relationship to Child: _____
  Cell Phone Number: _____

- First and Last Name: _____ Relationship to Child: _____
  Cell Phone Number: _____

Legal Information **Custodial Parent First and Last Name:**

_____

If parents are divorced or separated, who has custody? _____

*Are there any legal restrictions that would restrict the noncustodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?

☐ Yes ☐No

If yes, please provide legal documents stating restrictions and bring them to your visit or email them to our office at info@milkandhoneypeds.com.

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Billing Information

Responsible Party: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Patient ☐ Other
If other, please specify: _____

_____

What email address is preferred for billing e-statements? _____
If you are not the above responsible party the office will need authorization from that party. Please have them fill out this form and return it to the office.

Insurance Information - Please select one:

☐ **I have PPO insurance and I have verified that Milk and Honey Pediatrics, Dr. Dafna Ahdoot is IN NETWORK with my plan.**

☐ **I have HMO insurance and I have verified that Milk and Honey Pediatrics, Dr. Dafna Ahdoot is IN NETWORK with my plan and is assigned as the medical group.**

☐ **I have Medi-Cal insurance and I have verified that Milk and Honey Pediatrics, Dr. Dafna Ahdoot is IN NETWORK with my plan.**

☐ **I don't have insurance, OR Milk and Honey Pediatrics, Dr. Dafna Ahdoot is not in network with my insurance. I am responsible for payment at the time of visit.**

Insurance Company Name: _____ Policy / Subscribers ID #: _____
Group #: _____ Policy Holder's First and Last Name: _____
Policy Holder's Date of Birth: _____
Insurance Address for Submitting Claims: _____
(Located on the back of your insurance card)

How did you hear about us? _____

I request that payment of authorized commercial insurance benefits be made to Milk and Honey Pediatrics, Dr. Dafna Ahdoot, for any service furnished to me or my dependent by Milk and Honey Pediatrics providers. I authorize Milk and Honey Pediatrics, Dr. Dafna Ahdoot, to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible for paying certain amounts due the physician at the time of service. These amounts could include annual deductibles, copayments, charges denied as not covered by my commercial insurance carrier, and charges denied for services determined as not medically necessary. I further understand any fees associated with collecting reimbursement on my account, I will be responsible for paying all those fees.

DISCLAIMER: ***By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.***

Parent/Guardian Signature: _____ Date: _____

Thank you for choosing our pediatric office! We look forward to providing excellent care for your child. **Notice to Consumers. Medical Doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov**

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