Silverdale Pediatrics
Niran S. Al-Agba, M.D. and Saad K. Al-Agba, M.D.
9910 Levin Road NW, Suite 200
Silverdale, WA 98383
Phone 360-692-8588 · Fax 360-692-7030

PATIENT NAME ____ D.O.B. ____________ M/F
Last First Middle

Parent or Guardian ____ SSN# _______-_____-______
Last First Middle

Home
Address____
City State Zip

Mailing Address (if different)____
City State Zip

Home Phone # _______________________Work # _____________________ Cell # __________________

Email Address ____

Preferred reminder method (Check one): Call ___ Text ___ Email ___

Parent or Guardian ____ SSN# ________-_____-________
Last First Middle

Home
Address____
City State Zip

Mailing Address (if different) ____
City State Zip

Home Phone # ____________________Work # _______________________ Cell # __________________

Email
Address____

Preferred reminder method (Check one): Call___ Text___ Email ___

Is patient an American Indian or an Alaska Native? _____

MEDICAL INSURANCE INFORMATION

Name of Insurance __________________ Subscriber _____________________Subscriber D.O.B. __/__/____
Last First

SUBSCRIBER SSN:_____-____-_____ID# ______________________________ Group # _______________

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Name of 2ND Insurance ________________ Subscriber _______________________ Subscriber D.O.B. __/__/____
Last First
SUBSCRIBER SSN:____-___-_____ID# ________________________________ Group # _____________________

SIBLINGS SEEN AT OFFICE

_________________________________ ____________________________ _______________________________

Emergency Contact (Other than Parent): __________________RELATIONSHIP TO PATIENT___________________
Phone: __________________

Emergency Contact (Other than Parent): __________________RELATIONSHIP TO PATIENT_________________
Phone: __________________

PATIENT CONSENT INFORMATION

I agree to be contacted for routine appointments or follow-up regarding healthcare by phone. Payment is due when service is rendered unless prior arrangements have been made. Please call to cancel or reschedule an appointment by 9 AM the day of the appointment or there is a $50.00 fee for a missed appointment. A $50.00 NSF fee will be added for all returned checks. I assign my insurance benefits to be paid directly to the physician. Seattle Consulting Nurses charge $40.00 each. I agree to be financially responsible for any non-covered services. I authorize the release of any information required to process a claim. In addition, I agree to pay all fees accrued on my account if referred to a collection agency.

____

Signature of patient or legally authorized individual Date

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

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