UCSF Benioff Children's Hospital
Pediatric Multiple Sclerosis Center

Mailing Address:

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We welcome you to the Regional Pediatric Multiple Sclerosis (MS) Center at UCSF Medical Center. The Pediatric MS Center team is dedicated to the care of children and adolescents with MS and related diseases, such as acute demyelinating encephalomyelitis, Devic's disease and optic neuritis. We offer a multidisciplinary evaluation, which includes a clinical evaluation, neuropsychological testing, support around educational issues, and social work services.

Our team of neurology experts includes a MS Neurologist, Pediatric Neurologist, Neuropsychologist/School-Specialist and a Social Worker. When needed, a Neuro-Ophthalmologist is available as well.

Enclosed, please find information for you to read about our Center as well as New Patient Registration and Demographics, Personal and Family History forms. Please fill these out and send or fax them, along with a copy of the front and back of your insurance card, to my attention as soon as possible.

To be considered for financial assistance, complete the enclosed application and send or fax with the requested supporting documentation. I will contact you as soon as your application has been processed, usually in about 10 days.

Prior to your visit, we request you and/or your doctors provide our center with medical records relating to your neurological condition to help facilitate your evaluation. Please send or fax us the following:

Clinic records including chart notes, dictation, discharge summaries.
MRI film or CDs including reported results
Lumbar puncture results
Pertinent lab results
Immunization records
Authorization for visit from Insurance Company if applicable

This information will assist us in providing your child and family with the best care possible. Feel free to call 415-353-3939 if you have any questions or need assistance with the above. We look forward to meeting you.

Sincerely,

Elsa Casillas
Clinic Coordinator

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NEW PATIENT REGISTRATION

Patient Name:	Date of Birth
Address	
City	State Zip
Social Security Number	Race
Language	Translator Needed
Home Phone	Alternate Number:
Allergies:	
Email Address:	
Guarantor	Relationship to Patient
Address	
City	State Zip
Employer Name	
Address	
City	State Zip
Social Security Number	
Work Phone	Cell Phone

Insurance	**Group Name**
Address	
City	State Zip
Phone	
Subscriber Name	Relationship to Patient
ID/Policy Number	Group Number
Subscriber Date of Birth	Copay/Coinsurance
Please circle type of insurance:	HMO/PPO/EPO/Medical/ CCS

Primary Care Physician	
Address	
City	State Zip
Phone: Fax	
Referring Physician	
Address	
City	State Zip
Phone: Fax	

Emergency Contact	Relationship to Patient
Address	
City	State Zip
Home Phone	Cell/ Work Phone