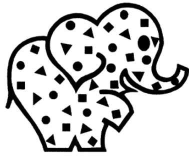

FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

1295 E. Hillsdale Blvd., Foster City, CA 94404 ♦ 650-574-2774 ♦ Fax 650-341-9236

PATIENT INFORMATION

☐ Dr. Aahlad ☐ Dr. Hung ☐ Dr. Jahan ☐ Dr. Yeh ☐ Dr. Kakkanad

Patient Information

Name of Patient and ALL Siblings (Last, First)	Sex	Birth date (MM/DD/YY)	Patient's cell phone (if applicable)
1. (Patient)________________	☐ M ☐ F	____ / ____ / ________	(______) ______ - ________
2. ________________	☐ M ☐ F	____ / ____ / ________	(______) ______ - ________
3. ________________	☐ M ☐ F	____ / ____ / ________	(______) ______ - ________
4. ________________	☐ M ☐ F	____ / ____ / ________	(______) ______ - ________
5. ________________	☐ M ☐ F	____ / ____ / ________	(______) ______ - ________

Parent or Guardian Information

1 Responsible Party Name ________________

Relationship to Patient ________________

Birth date ____ / ____ / ________

Address ________________

City________________State______Zip ________

Occupation ________________

Employer________________

Home Phone (______) ______ - __________ ☐

Work Phone (______) ______ - __________ Ext. ______ ☐

Cell Phone (______) ______ - __________ ☐

Email Address________________

***Patient(s) Lives With** ________________

2 Other Parent or Guardian________________

Relationship to Patient ________________

Birth date ____ / ____ / ________

Address ________________

City________________State______Zip ________

Occupation ________________

Employer________________

Home Phone (______) ______ - __________ ☐

Work Phone (______) ______ - __________ Ext. ______ ☐

Cell Phone (______) ______ - __________ ☐

Email Address________________

Referred by ________________

Emergency Contact Information

In an emergency please contact (other than above) ________________

Relationship ________________ Phone (______) ______ - ________________

Insurance Information

____

Insurance Name ID#

____

Subscriber Name Group#

I UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING MY INSURANCE CARD, COMPLETE INSURANCE INFORMATION AND COPAYMENT AT THE TIME OF MY CHILD'S VISIT. AS APPROPRIATE, I MAY BE BILLED FOR ANY INSURANCE DEDUCTIBLE OR SERVICES THAT ARE NOT COVERED BENEFITS.

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN.

SIGNED:____DATE________________

I HAVE RECEIVED A COPY OF FOSTER CITY PEDIATRICS' PRIVACY PRACTICES

SIGNED:____DATE________________