



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. Yeh Dr. Smith

Patient Information

Name of Patient and ALL Siblings (Last, First)	Sex	Birth date (MM/DD/YY)	Patient's cell phone (if applicable)
1. (Patient) _____	<input type="checkbox"/> M <input type="checkbox"/> F	___/___/___	(____) ____ - _____
2. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___/___/___	(____) ____ - _____
3. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___/___/___	(____) ____ - _____
4. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___/___/___	(____) ____ - _____
5. _____	<input type="checkbox"/> M <input type="checkbox"/> F	___/___/___	(____) ____ - _____

Parent or Guardian Information

1 Responsible Party Name _____	2 Other Parent or Guardian _____
Relationship to Patient _____	Relationship to Patient _____
Birth date ___/___/___	Birth date ___/___/___
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Occupation _____	Occupation _____
Employer _____	Employer _____
Primary Phone (____) ____ - _____ <input type="checkbox"/>	Primary Phone (____) ____ - _____ <input type="checkbox"/>
Work Phone (____) ____ - _____ Ext. ____ <input type="checkbox"/>	Work Phone (____) ____ - _____ Ext. ____ <input type="checkbox"/>
Cell Phone (____) ____ - _____ <input type="checkbox"/>	Cell Phone (____) ____ - _____ <input type="checkbox"/>
Email Address _____	Email Address _____
*Patient(s) Lives With _____	Referred by _____
Primary Contact Name _____	Relationship to Patient _____

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 _____