PURI PEDIATRIC
Medical Group, Inc.

2243 Mowry Avenue, Suite F, Fremont, CA 94538
Phone 510.797.7766; Fax 510.797.0595

Patient Registration Form

Patient Information (PLEASE PRINT)

Name:

Address:

City/State/Zip:

Age: Sex: Birthdate:

How did you find out about this office?

Patient Phone (if over 16 yrs.):

Message phone of someone not living at home:

Name:

Relation: Phone: ( ) -

Name of your other children (if cared for by Dr. Puri):

Father's Name:

Address:

City/State/Zip:

Birthdate: SS#

Primary Phone:

E-mail Address:

Employer:

Address:

City/State/Zip:

Insurance Name:

Insurance ID# Group#

Insurance: PRIMARY SECONDARY

Race/Ethnicity (Optional):

Religion (Optional):

Mother's Name:

Address:

City/State/Zip:

Birthdate: SS#

Primary Phone:

E-mail Address:

Employer:

Address:

City/State/Zip:

Insurance Name:

Insurance ID# Group#

Insurance: PRIMARY SECONDARY

Race/Ethnicity (Optional):

Religion (Optional):

ASSIGNMENT OF BENEFITS & AUTHORIZATION RELEASE INFORMATION: I, the undersigned, authorize payment of medical benefits to PURI PEDIATRICS MEDICAL GROUP for any services furnished to my child. I understand that I am financially responsible for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection and/or court costs and reasonable attorney's fees should this be required. I further understand that a photocopy of this form shall be deemed as valid and effective as the original. Should any check be returned to PURI PEDIATRICS MEDICAL GROUP due to insufficient funds or any other reason, the undersigned authorizes PURI PEDIATRICS MEDICAL GROUP to charge my Visa or MasterCard any outstanding balance on my account plus a returned check charge of $15.00 (Fifteen dollars). I also authorize you to release any information concerning health care, advice and treatment to my insurance company and/or other physicians who may consult on my child's case.

Signature: X Date:

DIVORCED PARENTS: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. WE WILL NOT BILL THE OTHER PARENT.

CONSENT TO TREATMENT OF MINOR: I, being, the parent/guardian of ____________________, do hereby consent, authorize, and request PURI PEDIATRICS MEDICAL GROUP to administer such treatment advisable, necessary, or requested on the above minor.

Signature: X Date: