Pan and Hsu Pediatrics, Inc.

DEMOGRAPHICS

Patient name: _____

Gender: Male or Female Birthdate: _____ Race: _____

Address: _____
Street City State Zip Code

Primary Telephone (____)_____ Secondary Telephone (____)_____

Name of Emergency Contact: _____ Relationship to patient:_____
(other than Mother or Father)
Telephone (____)_____

Please circle one

Mother/Father/Foster Parent/Guardian

Name: _____

DOB: _____

Email: _____

Employer: _____

Work Telephone (____)_____

Please circle one

Mother/Father/Foster Parent/Guardian

Name: _____

DOB: _____

Email: _____

Employer: _____

Work Telephone (____)_____

Siblings

Name: _____ DOB_____

Name: _____ DOB_____

Name: _____ DOB_____

Are the parents of the child: Married/ Divorced/ Separated/ Living together

If divorced or separated, what are the legal custody arrangements for the child?

Physical custody:

Name: _____ Relationship to patient: _____

Name(s) _____ Relationship to patient: _____

BILLING

Primary Insurance_____ Policy Number_____

Secondary Insurance _____ Policy Number _____

Policy Holder's Name_____

Policy Holder's DOB_____ SSN_____

Relationship to patient _____

How did you hear about our office? _____

OFFICE POLICY

NO-SHOW Policy: Please call for any changes/cancellations to be made at least a day before the scheduled appointment. Otherwise, a scheduled appointment may not be available to you after two missed appointments. We will then ask you to walk in for your next appointment.

Late arrival: If you are late, you may be asked to re-schedule your appointment unless the physician's schedule can still accommodate you.

FINANCIAL AGREEMENT/RESPONSIBLE PARTY *(Read before signing)*

I understand that fees are payable when service is rendered unless Pan and Hsu Pediatrics' physicians are contracted with my insurance company and my insurance company will pay all fees at 100%. I understand that I am responsible for all non-covered services, co-insurance fees, deductibles, and co-payments.

I understand that if my account is turned over to a collection agency, I will be subjected to a $20 processing fee. In the event that my account is turned over to a collection agency twice, I understand that my child/children will no longer be treated by the physicians at Pan and Hsu Pediatrics.

I understand that if my health insurance company denies payment for any reasons, I will be fully responsible for payment.

I have read and understand Pan and Hsu Pediatrics' policies and financial agreement.

Name_____

Relationship to Patient_____

Signature_____ Date_____