



**PURI PEDIATRIC  
Medical Group, Inc.**

**Veena Puri, MD, FAAP  
Hari Puri, MD, FAAP**

***Patient  
Registration  
Form***

*2243 Mowry Avenue, Suite F  
Fremont, California 94538*

**Patient Information (PLEASE PRINT)**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Message phone of someone not living at home:**  
Name: \_\_\_\_\_  
Relation: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Name of your other children (if cared for by Dr. Puri): \_\_\_\_\_

**How did you find out about this office?**

Father's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_  
Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance:  PRIMARY  SECONDARY  
Are well-care shots covered?  Yes  No  
Cr. Card: VISA/MC # \_\_\_\_\_ Exp: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_  
Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance:  PRIMARY  SECONDARY  
Are well-care shots covered?  Yes  No  
Cr. Card: VISA/MC # \_\_\_\_\_ Exp: \_\_\_\_\_

**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: \_\_\_\_\_ 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: \_\_\_\_\_ Date: \_\_\_\_\_