



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: _____

How did you find out about this office?

Father's Name: _____

Address: _____

City/State/Zip: _____

Birthdate: _____ SS# _____

Home Phone: _____ Work: _____

Cell Phone: _____

E-mail Address: _____

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: _____

Message phone of someone not living at home:

Name: _____

Relation: _____ Phone: (_____) _____

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

Mother's Name: _____

Address: _____

City/State/Zip: _____

Birthdate: _____ SS# _____

Home Phone: _____ Work: _____

Cell Phone: _____

E-mail Address: _____

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: _____