PEDIATRIC PATIENT REGISTRATION

Patel Medical Corporation (PMC), Mandakini D. Patel, M.D., FAAP
200 Jose Figueres Avenue #340
San Jose, CA 95116 Ph: 408-729-1220

Patient Last Name: **First name**: Middle: Sex:
Address**:** **APT #**
City: State: Zip:
Parents/Guardian's **CELL PHONE**: **HOME PHONE**:
Date of Birth: / / Social Security No.

INSURANCE (PRIMARY):
Insured Name: Insured relationship:
Insurance ID: Ins. Group No.: Ins. Ph:
INSURANCE (SECOND):
Insured Name: Insured relationship:
Insurance ID: Ins. Group No.: Ins. Ph:

Father: Last Name: **First name**: Date of birth: SSN:
Address: City: State: Zip:
CELL PHONE: HOME PHONE: WORK PHONES:
CA Driver's License No. or any governmental ID:
Employer Name & Address:
Employer Phone number:
Mother: Last Name: **First name**: Date of birth: SSN:
Address: City: State: Zip:
CELL PHONE: HOME PHONE: WORK PHONES:
CA Driver's License No. or any governmental ID:
Employer Name & Address:
Employer Phone number:

Emergency contact *not* living with you:
NAME(S): Relationship:
Full Address: City: State: Zip:
Home Phone: Cell Phone:

FOR PEDIATRIC PATIENTS: I certify that I am the parent/legal guardian and I agree to accompany my children/ward on their first visit and on each visit thereafter.
I agree to pay PMC the deductible, co-insurance and copayment at the time of visit by cash or check. I agree to the terms & conditions of the PMC and future amendments. I am financially responsible for charges of services provided by PMC/Dr. Patel on me (my children) for services not covered by my insurance. I agree to notify PMC promptly in writing of any change in my insurance/address/phone no. (*set up to receive voice messages).*
I consent PMC/Dr. Patel to treatment of all medical conditions and preventive care including immunizations for me (my children). I authorize release of any medical information on me (my children) by PMC/Dr. Patel's office necessary to process the claim and collection of the charges &/or when pertinent to the care. I authorize and request my insurance to directly pay Patel Medical Corp. promptly for my (my children's) medical benefits.

_____ / /
SIGNATURE OF AUTHORIZED PARENT/GUARDIAN/INSURED: DATE: