PATIENT INFORMATION

Patient Name _____ Birth Date___/___/____ M ____ F ____
Last First Middle Mo Day Yr

Address _____
Street Apt# City Zip

Name of person financially responsible for patient _____

Mother: Name _____ Birth Date_____ Soc. Sec.# _____Driver License#_____
Address _____
Employer_____ Occupation_____ Marital Status [] Married [] Single [] Other
Phone#: Home _____ Cell _____ Work _____
E-mail address: _____ Fax#: _____
Insurance Co._____ ID#_____
Father: Name _____ Birth Date_____ Soc. Sec.# _____Driver License#_____
Address _____
Employer_____ Occupation_____ Marital Status [] Married [] Single [] Other
Phone#: Home _____ Cell _____ Work _____
E-mail address: _____ Fax#: _____
Insurance Co._____ ID#_____

Primary Insurance of patient
Name of Subscriber_____
Name of Insurance company_____
Address_____
Address_____
City_____
State_____Zip_____
Phone #_____
ID#_____
Group#_____
Plan or contract code_____
Name of Medical Group_____

Secondary Insurance of patient
Name of Subscriber_____
Name of Insurance company_____
Address_____
Address_____
City_____
State_____Zip_____
Phone #_____
ID#_____
Group#_____
Plan or contract code_____
Name of Medical Group_____

Emergency Contact Name/Relationship _____Phone#_____

Who referred you to this office? _____

CONSENT TO TREAT AND PAYMENT AGREEMENT

I, the undersigned parent or legal guardian of _____, a minor, give consent for diagnostic procedures, including examinations, X-ray, blood tests, immunizations and other treatments recommended by Bih-ju Ruby Huang, MD. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by the aforementioned physician in the exercise of her best judgment. It is understood that efforts shall be made to contact the undersigned prior to rendering treatment but that none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. It shall remain effective until the child is eighteen years old or otherwise specified, or authorization is cancelled in writing.

I hereby also authorize Bih-ju Ruby Huang, MD to release any medical information of the above named to insurance company, and/or Medicare for coordination of services as indicated. I hereby assign to Bih-ju Ruby Huang, MD financial payments for health care, medical or surgical services rendered on the child's behalf, for which he/she is eligible. I understand that I am financially responsible for charges not covered by this assignment, which may include legal/collection fees in the event of non-payment. I understand that I am responsible to pay charges, co-payment or deductible applied to office visit at time of visit.

I understand that I may request a copy of this authorization, I attest that I have read, and that I understand this authorization.

_____

Name of parent or legal guardian Signature of parent or legal guardian Date