PATIENT INFORMATION

Name (Last, First)	SSN#	Date:	New Patient Updated Info
Address (include City, State, Zip)		Email:	
Home Phone	Cell Phone	DOB	Sex M/F
Emergency Contact (Name, Relationship, Phone Number)		Referred By	
Pharmacy (Name, Location)		Pharmacy#	
Patient's Race *Caucasian African American Hispanic Native American Other*_____ *Refused*			
Patient's Primary Language: English Spanish Asian Hindi Other:_____			

RESPONSIBLE PARENT/GUARANTOR INFORMATION

Name	Sex	Relationship to Patient	Birthdate	ID#
Address(city,state, zip)		Home Phone	Social Security	
Employer	Employer's Address (include City, State, Zip)		Work Phone	

OTHER PATIENT INFORMATION

Name	Sex	Relationship to Patient	Birth date	ID #
Address(include City, State, Zip)		Home Phone	Social Security Number	

INSURANCE INFORMATION(Please present Insurance Card's to receptionist IN ADDITION to completing the area Below

Primary Insurance	Identification Number	Group #	Insurance#
Name of Policy Holder	DOB	Patient's Relationship to policy holder	
Secondary Ins	Identification#	Group#	Ins Co 800 Number
Name of Policy Holder	Date of Birth	Patients Relationship to Policy Holder	

General Consent To Treat

I am the parent/guardian of_____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient. I authorize and consent Dr. Bhuchar for treatment as necessary or desirable for the care of the patient, including, but not restricted to medical care, treatment, immunizations, and diagnostic test or other studies that may be used by the attending physician or his nurses or qualified designate, until I withdraw my consent.

_____Please Initial

I request that payment of authorized insurance benefits be made on my behalf to **Dr. Subodh Bhuchar/Sugar Land Med- Ped Clinic** for any services furnished to me. I authorize any holder of medical information about me or my dependents to release to the insurance company any information needed to determine benefits or the benefits payable for related services. A photocopy of the assignment is to be considered as valid as the original until revoked. I understand that Iam financially responsible for all charges whether or not covered by said insurance , and agree to promptly pay any balance remaining after insurance payment. I authorize **Dr. Subodh Bhuchar/Sugar Land Med-Ped Clinic** to initiate a complaint to the Insurance Commissioner, for any reason, on my behalf.

Patient/Parent/Guarantor's Signature_____ Date_____