Patient Information: New______ Update_____ Date____________

____
(Last Name) (First Name) (Middle)
Birth Date: _______________ Age:____ Sex:_____ SS# ______________________
Street Address: ___________________________City/State:_________________Zip:__________
Home #:________________Daytime #: _________________Cell#:______________________
Email:_______________________________________ Fax:________________________

Mothers Information:

____ ______________________
(Last Name) (First Name) Date of Birth
SS#:___________________________ Marital Status: Married/Divorced/Single/Widowed
Street Address:____________________________City/State:_____________Zip:_________
Employer Name/Address:____
Work #:___________________ Day/Cell#:________________ Home#:_____________

Fathers Information:

____ ___________________________
(Last Name) (First Name) Date of Birth
SS#:___________________________ Marital Status: Married/Divorced/Single/Widowed
Street Address:_____________________________City/State:_____________Zip:_________
Employer Name/Address:____
Work#:___________________ Day/Cell#:________________Home#:______________

Emergency Contact (other than parent)

________________________________ _________________ _____________
Name Relationship Phone #

Insurance Information:

_______________________ ___________________ _______________
Insurance Company ID# Group #

______________________________________ ______ _______________
Policy Holder Last Name First Sex Date of Birth

____________________________ ____________ ______________
Insurance Co. Address City/State Zip

I authorize treatment for my child if brought in by someone else in such case that I am unable to bring my child in personally. I hereby consent to and authorize the administration of all treatment that may be considered advisable and necessary. I hereby authorize Sindu Pillai, M.D. to release any information acquired in the course of my child's examination and treatment. I understand that I am financially responsible for all expenses incurred regardless of insurance coverage.
Authorization to pay physician: I hereby authorize payment directly to Dr. Pillai by my insurance for the services she provides to my child/children.

Signature:____ Date:________________
Relationship to Patient:_________________________________
How did you hear about our office?____