Dr. Indira Vemuri, PC

Date: ______________

Patient: _____________________________________ DOB: __________ Male: __ Female: __

(Last Name, First Name, Middle Initial)

Parent/Guardian Information

Mother: _____________________________________ DOB: __________

(Last Name, First Name, Middle Initial)

Single: ______ Married: ______ Separated: ______ Divorced: ______

Street Address: ____ City: __________ State: ____

ZIP Code: _________ Home Phone: _________________ Cell Phone: __________________

Occupation: ______________________________ Employer: _______________________________

Business Phone: _____________________ City: __________ State: ____ ZIP Code: _________

Father: _____________________________________ DOB: __________

(Last Name, First Name, Middle Initial)

Single: ______ Married: ______ Separated: ______ Divorced: ______

Street Address: ____ City: __________ State: ____

ZIP Code: _________ Home Phone: _________________ Cell Phone: __________________

Occupation: ______________________________ Employer: _______________________________

Business Phone: _____________________ City: __________ State: ____ ZIP Code: _________

*If mother and father are not living together or if the child does not live with the parents, what is the child's custody status?

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: ____________________________ Relationship: ___________ Phone: ______________

Name: ____________________________ Relationship: ___________ Phone: ______________

PERSONS AUTHORIZED TO ACCOMPANY AND PROVIDE CONSENT FOR TREATMENT OTHER THAN PATIENTS:

Name: ____________________________ Relationship: ___________ Phone: ______________

Name: ____________________________ Relationship: ___________ Phone: ______________

PREFERRED PHARMACY NAME: ____

Location: _____________________________________ Phone: ___________________________

INSURANCE INFORMATION

Primary Insurance Name: _________________________ Responsible Party: _______________

Group #: _____________________________________ Subscriber #: ______________________

Name of Secondary

Group #: _____________________________________ Subscriber #: ______________________

Relationship to Patient: ____________________ SSN: ________________ DOB: ___________

Home Phone: _____________________ Cell Phone: _____________________

Street Address: ____ City: __________ State: ____

ZIP Code: _________

In order to comply with the EHR system, federal, and state reporting and record keeping when using state provide vaccines please indicate one of the following

Family smoking (Y/N): Race: Caucasian: __ Black: __ Hispanic __ Native American: __ Other: __

Language: ______________________________ Ethnicity: ______________________________________

I, Parent/Guardian, consent my minor child's treatment and care of medical, surgical or other services under the general and specific instructions of Dr. Vemuri, her assistants, or her designee as is necessary in her judgement.

INSURANCE RELEASE: I hereby Authorize the named doctor above to furnish to insurance all information which may require concerning my Child's illness/injury for reimbursement of services rendered.

ASSIGNMENT OF BENEFIT: I hereby assign to the above name doctor, my Child's benefits to medical services. This authorization becomes effective immediately and shall remain in effect indefinitely unless revoked in writing.

AUTHORIZATION TO TREAT A MINOR

I, the parent, or legal guardian, acting behalf of Minor's Name: ___________________________
Date of Birth: ______________, hereby authorize physical examinations, diagnostic test (including blood, urine, and skin tests, immunizations), and non-surgical outpatient medical treatment of the conditions diagnosed for the above minor to be performed by physician, physician supervised assistants, and or nurse practitioners and staff at Dr. Vemuri's Office located at 17705 Hale Ave, Ste I1 in Morgan Hill, CA 95037

Signature of Parent/Guardian: _______________________________ Date: ________________
Relationship to Minor: ______________________

AUTORIZACIÓN DE UNA TERCERA PERSONA PARA DAR TRATAMIENTO MÉDICA A UN MENOR DE EDAD

(Yo)(Nosotros), padres, del suscrito(a) y con la custodia/tutela legal de nombre del paciente: ___________________________ fecha de nacimiento del menor de edad _________________, por media de esta autorizo a la Dra. Indira Vemuri como agente del suscrito y doy nuestro consentimiento para que le tomen radiografías, le hagan pruebas de diagnóstico (incluyendo análisis de sangre, orina, pruebas de piel, inmunizaciones) y tratamiento médico externo (no incluye cirugía), que se considere prudente y que se efectúe bajo la supervisión general o especial de un Doctor en Medicina, con autorización para practicar de acuerdo a lo previsto en la Acta de Practica Medicina (Medical Practice Act), ya sea que dichos tratamientos o diagnósticos se efectúen en la Oficina de la Dra. Indira Vemuri localizada en 17705 Hale Ave, Ste I1 in Morgan Hill, CA 95037

Firma del of Padre/tutor Legal: _______________________________ Fecha: ________________
Parentesco con el menor: ______________________

FINANCIAL AGREEMENT: The above signed agrees where he/she sign the forms as a patient or agent of the patient, that in consideration of the services to be rendered by the above doctor he/she obligates himself to pay the account in accordance with regular fee and terms, which are subject to change without notice. In the event this account is referred to collections, the patient shall pay reasonable attorney fees and collection expenses. Quoted fees are only an estimate of approximate charges. Any additional charges for services will be billed to you.

HMO CONDITIONAL ENROLLMENT: I understand that if this or any other visit precedes the effective date of my Child's coverage with the above named doctor I will be held responsible for all charges incurred. If the coverage is terminated, I will become responsible for all charges from the date of termination.

INFORMACIÓN DE ASEGURANZA:

CONTRATO ASEGURANZA: Yo autorizo el nombre del doctor de arriba a dar información a mi aseguranza la cual ellos requieran basado a la enfermedad de mi hijo/hija para reembolso del servicio

ASIGNACIÓN DE BENEFICIOS: Yo doy permiso al doctor nombrado de arriba para dar atención médica a mi hijo/a. Esta autorización toma efecto de inmediato y hasta revocar por escrito

CONTRATO FINANCIERO: Yo entiendo que al firmar este contrato soy responsable de los pagos de la cuenta y los cobros sin aviso. Si la cuenta es mandada a colección, el paciente o agencia de pagar el precio o de la cuenta de la corte. La cuota es un presupuesto aproximado de los cobros. Cobros adicionales por servicios serán cobrados a usted.

HMO MATRÍCULA CONDICIONAL: Yo entiendo que si mi cubrimiento ha sido descontinuado, yo soy responsable por los cobros.