Dr. Indira Vemuri MD
Pediatric Care

Dr. Indira Vemuri MD
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WELCOME TO THE PRACTICE

New Patient Registration

Please print clearly and complete every section. Bring this form and your insurance card to your first visit.

PATIENT

LAST NAME, FIRST NAME, MIDDLE INITIAL _____ DATE OF BIRTH _____

SEX ☐ Male ☐ Female

PARENT / GUARDIAN — MOTHER

LAST NAME, FIRST NAME, MIDDLE INITIAL _____ DATE OF BIRTH _____

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ OCCUPATION _____

EMPLOYER _____ BUSINESS PHONE _____

PARENT / GUARDIAN — FATHER

LAST NAME, FIRST NAME, MIDDLE INITIAL _____ DATE OF BIRTH _____

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ OCCUPATION _____

EMPLOYER _____ BUSINESS PHONE _____

If the mother and father do not live together, or the child does not live with the parents, please note the child's custody status: _____

IN CASE OF EMERGENCY

NAME | RELATIONSHIP | PHONE

NAME | RELATIONSHIP | PHONE

AUTHORIZED TO ACCOMPANY & CONSENT TO TREATMENT (OTHER THAN PARENTS)

NAME | RELATIONSHIP | PHONE

NAME | RELATIONSHIP | PHONE

PREFERRED PHARMACY

PHARMACY NAME | LOCATION | PHONE

INSURANCE

PRIMARY INSURANCE NAME | RESPONSIBLE PARTY

GROUP # | SUBSCRIBER # | SECONDARY INSURANCE NAME

GROUP # | SUBSCRIBER # | RELATIONSHIP TO PATIENT

SSN | DATE OF BIRTH | HOME PHONE

CELL PHONE

STREET ADDRESS | CITY | STATE | ZIP

STATE VACCINE REPORTING (EHR)

To comply with EHR, federal, and state reporting and record-keeping when using state-provided vaccines, please complete the following.

FAMILY SMOKING ☐ Yes ☐ No

RACE ☐ Caucasian ☐ Black ☐ Hispanic ☐ Native American ☐ Other

LANGUAGE | ETHNICITY

Consent to treat. I, the parent/guardian, consent to my minor child's treatment and care — medical, surgical, or other services — under the general and specific instructions of Dr. Vemuri, her assistants, or her designee, as necessary in her judgment.

Insurance release. I authorize the named doctor to furnish to my insurance all information required concerning my child's illness or injury for reimbursement of services rendered.

Assignment of benefits. I assign to the named doctor my child's benefits for medical services. This authorization becomes effective immediately and remains in effect indefinitely unless revoked in writing.

AUTHORIZATION TO TREAT A MINOR

I, the parent or legal guardian, acting on behalf of the minor named below, hereby authorize physical examinations, diagnostic tests (including blood, urine, and skin tests, and immunizations), and non-surgical outpatient medical treatment of the conditions diagnosed for the above minor, to be performed by a physician, physician-supervised assistants, and/or nurse practitioners and staff at **Dr. Vemuri's office, located at 15585 Monterey Rd, Suite A, Morgan Hill, CA 95037**.

MINOR'S NAME

DATE OF BIRTH

PARENT / GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO MINOR

ESPAÑOL

AUTORIZACIÓN PARA TRATAR A UN MENOR DE EDAD

(Yo)(Nosotros), padres del suscrito(a) y con la custodia/tutela legal del paciente nombrado abajo, por medio 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 e inmunizaciones) y tratamiento médico externo (no incluye cirugía) que se considere prudente, bajo la supervisión general o especial de un Doctor en Medicina y conforme a lo previsto en el Acta de Práctica Médica (Medical Practice Act), ya sea que dichos tratamientos o diagnósticos se efectúen en **la oficina de la Dra. Indira Vemuri, localizada en 15585 Monterey Rd, Suite A, Morgan Hill, CA 95037**.

FIRMA DEL PADRE / TUTOR LEGAL

FECHA

PARENTESCO CON EL MENOR

FINANCIAL AGREEMENT

Financial responsibility. The undersigned, signing as the patient or as the patient's agent, agrees that in consideration of the services rendered by the doctor, he/she is obligated to pay the account in accordance with the regular fees and terms, which are subject to change without notice. If 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 named doctor, I will be responsible for all charges incurred. If coverage is terminated, I become responsible for all charges from the date of termination.

ESPAÑOL

CONTRATO FINANCIERO

Contrato de aseguranza. Yo autorizo al doctor nombrado arriba a dar a mi aseguranza la información que requieran, basada en la enfermedad de mi hijo/hija, para el reembolso del servicio.

Asignación de beneficios. Yo doy permiso al doctor nombrado arriba para dar atención médica a mi hijo/a. Esta autorización toma efecto de inmediato y hasta revocarse por escrito.

Contrato financiero. Yo entiendo que, al firmar este contrato, soy responsable de los pagos de la cuenta y de los cobros sin previo aviso. Si la cuenta se manda a colección, el paciente es responsable del precio o de los costos de la cuenta y de la corte. La cuota es un presupuesto aproximado de los cobros; cobros adicionales por servicios le serán cobrados a usted.

Matrícula condicional HMO. Yo entiendo que si mi cobertura ha sido descontinuada, soy responsable por los cobros.

PARENT / GUARDIAN SIGNATURE · FIRMA DEL PADRE / TUTOR

DATE · FECHA