## Welcome to our practice!

Sandra A. Hollenberg, M.D.
Pramila Agrawal, M.D.
Carrie Knoll, M.D.
James Warren, M.D.
Ericka Hong, M.D.
Kent Fung, M.D.
Toya A. Tillis, M.D.

**We strive to make each visit pleasant and comfortable for you child/adolescent.**
**Please completly fill out this form.**

Patient Account: Date :

### PATIENT

Name: ______________________________ Gender:__________

Date of birth: ______________________ Home Phone: ______________________

Address: ______________________________ Apt# _______

City, State, Zip code: ______________________________

Language(s) you speak at home: ______________________________

### SIBLINGS

Name : ______________________ Name : ______________________

Date of Birth: _____________ Gender :______ Date of Birth: _____________ Gender: _______

Name : ______________________ Name : ______________________

Date of Birth: _____________ Gender :______ Date of Birth: _____________ Gender: _______

Name : ______________________ Name : ______________________

Date of Birth: _____________ Gender :______ Date of Birth: _____________ Gender: _______

### AUTHORIZATION AND RELEASE

I hereby authorize medical or surgical treatment by the doctor in person or provider under his/her supervision. I certify that all information given by me is correct. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my dependent's insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my dependent's insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby authorize medical payment and/or medical information to be released directly to Frederick A. Lauppe, Jr., M.D., Sandra A. Hollenberg, M.D., Pramila Agrawal, M.D., Carrie Knoll, M.D., James T. Warren, M.D., Ericka Hong, M.D., and Kent Fung, M.D. at 250 W. Bonita Ave., Suite 200, Pomona, CA, 91767.

Responsible Party Signature: ______________________________ Date:_______________

Patient Name: Date of Birth: Account:

**MOTHER**

Name: ___________________________________________________ Please circle: Mother, Stepmother, or Guardian

Date of Birth: _____________ Email Address: ______________________________________________________

Home Address: _________________________________________________________________________________

City, State, Zip Code: ____________________________________________________________________________

Home Phone: _____________________________________Cell Phone: ____________________________________

Occupation: ________________________________ Employer**:** ___________________________________________

Employer city/state: _____________________________________ Work Phone: ____________________________

**FATHER**

Name: ___________________________________________________ Please circle: Father, Stepfather, or Guardian

Date of Birth: _______________ Email Address: ____________________________________________________

Home Address: _________________________________________________________________________________

City, State, Zip Code: ____________________________________________________________________________

Home Phone: _____________________________________Cell Phone: ____________________________________

Occupation: ________________________________ Employer**:** ___________________________________________

Employer city/state: _____________________________________ Work Phone: ____________________________

Parent's marital status: Single Married Divorced Widowed Separated

**ALTERNATE CONTACTS IF UNABLE TO REACH YOU BY PHONE OR MAIL FOR ANY REASON**

Name: ______________________________________________ Relationship to child: _________________________

Address: ______________________________________________________ Phone #: __________________________

Name: ______________________________________________ Relationship to child: _________________________

Address: ______________________________________________________ Phone #: __________________________

Name: ______________________________________________ Relationship to child: _________________________

Address: ______________________________________________________ Phone #: __________________________

**PATIENT'S PRIMARY INSURANCE**

Insured's Name: ___________________________________________________ Insured's DOB: ________________

Insurance Company:_________________________________________________________________________________

Subscriber Member #: ______________________________________________ Group #: _______________________

**PATIENT'S SECONDARY INSURANCE**

Insured's Name: ___________________________________________________ Insured's DOB:________________

Insurance Company:______________________________________________________________________________

Subscriber Member #: ______________________________________________ Group #: _______________________